

4282

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY A. A.		MARYLAND		STATE Md.		COUNTY A. A.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Riviera Beach				OR TOWN Riviera Beach		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kenwood and Greenway				STREET ADDRESS (If rural give location) Kenwood & Greenway			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Dry) (Year)			
HENRY ARTES				May 24 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
male		white		married		Aug. 1, 1868	
9. AGE last birthday:		10. USUAL OCCUPATION..Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
86 yrs.		Cutter		Wash., D. C.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Henry Artes				Johanna Seaboe			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
3 no --				212-14-0054 A		Mr. Henry Artes - 5206 Catalpha Rd.	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Cerebral hemorrhage				1 month	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) generalized arteriosclerosis				Not known	
(c) left hemiplegia				1 month	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?	
22. I hereby certify that I attended the deceased from Mar. 18, 1955, to May 24, 1955, that I last saw the deceased alive on May 24, 1955, and that death occurred at 11:00 A.M., from the causes and on the date stated above.					
SIGNATURE R. M. McLaughlin		(Degree or title) M.D.		ADDRESS Pasadena, Md. DATE SIGNED May 24, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		5/27/55		Loudon Park Cem.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
5-25-55		R. M. McLaughlin		J. J. Tischer & Sons - Balto 17 Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4827

5092



INSTRUCTIONS

1 **M** **1**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4257

CERTIFICATE OF DEATH

04248

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A. Co.</u>		MARYLAND		STATE <u>Mo.</u>		COUNTY <u>A.A. Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 518 BURUSIDE ST.</u>				STREET ADDRESS <u>518 BURUSIDE ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>VERONICA</u> (Middle) <u>BENDA</u> (Last)				(Month) <u>5</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>5/24/1887</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>J.J. BENDA JR. # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) <u>carcinoma of pancreas with gen. metastasis</u> <u>5 mos.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>UNDERLYING CAUSE LAST.</u> DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION <u>3/25/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ca pancreas c metastasis</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/4/55</u> , 19 <u>55</u> , to <u>5/9/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/8/55</u> , 19 <u>55</u> , and that death occurred at <u>10:15 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Borman</u> M.D.				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>5/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		LOCATION (City, town, or county) <u>Annapolis Mo.</u>	
24. REC'D BY REGISTRAR <u>May 11, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Benda</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Mo.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERK

16. SIGNATURE OF CHURCH CLERK

17. SIGNATURE OF MINISTER

18. SIGNATURE OF RABBI

19. SIGNATURE OF PRIEST

20. SIGNATURE OF BISHOP

21. SIGNATURE OF ARCHBISHOP

22. SIGNATURE OF PAPAL LEGATE

23. SIGNATURE OF APOSTOLIC NUNCIUS

24. SIGNATURE OF VICE-LEGATE

25. SIGNATURE OF CHANCELLOR

26. SIGNATURE OF SECRETARY

27. SIGNATURE OF ASSISTANT SECRETARY

28. SIGNATURE OF CLERICAL ASSISTANT

29. SIGNATURE OF CHIEF CLERK

30. SIGNATURE OF DEPUTY CHIEF CLERK

31. SIGNATURE OF CLERICAL ASSISTANT

32. SIGNATURE OF CHIEF CLERK

33. SIGNATURE OF DEPUTY CHIEF CLERK

34. SIGNATURE OF CLERICAL ASSISTANT

35. SIGNATURE OF CHIEF CLERK

36. SIGNATURE OF DEPUTY CHIEF CLERK

37. SIGNATURE OF CLERICAL ASSISTANT

38. SIGNATURE OF CHIEF CLERK

39. SIGNATURE OF DEPUTY CHIEF CLERK

40. SIGNATURE OF CLERICAL ASSISTANT

41. SIGNATURE OF CHIEF CLERK

42. SIGNATURE OF DEPUTY CHIEF CLERK

43. SIGNATURE OF CLERICAL ASSISTANT

44. SIGNATURE OF CHIEF CLERK

45. SIGNATURE OF DEPUTY CHIEF CLERK

46. SIGNATURE OF CLERICAL ASSISTANT

47. SIGNATURE OF CHIEF CLERK

48. SIGNATURE OF DEPUTY CHIEF CLERK

49. SIGNATURE OF CLERICAL ASSISTANT

50. SIGNATURE OF CHIEF CLERK

BUREAU V. S.

MAY 13 1955

RECEIVED

4258

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>		STREET ADDRESS (If rural, give location) <u>23 Francis St.</u>	
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>E.</u> (Middle) <u>Benedict</u> (Last)		4. DATE OF DEATH <u>5-28-55</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Aug 3-1898</u>
9. AGE last birthday <u>56</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Marine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N. Band</u>	
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Benedict</u>		14. MOTHER'S MAIDEN NAME <u>Eva Wolfe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>II</u>		16. SOCIAL SECURITY NO. <u>212-28-1619</u>	
17. INFORMANT AND ADDRESS <u>Louisa V. Benedict</u>		18. <u>2</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 1, 1955</u>	<u>National Cemetery</u>	<u>Annapolis</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 1, 1955</u>	<u>J. J. O'Donoghue</u>	<u>John M. Taylor Sons</u>	<u>Annapolis Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1955

BUREAU V. 3

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4259

CERTIFICATE OF DEATH

04250

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>6 days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>USN Hospital</u>				STREET ADDRESS (If rural give location) <u>1519 Light Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles Andrew BOHLE</u>				<u>May 1 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>Cau</u>	<u>M</u>	<u>3-29-94</u>	<u>61</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>USN</u>		<u>Retired</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Conrad BOHLE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH WIEGAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, ap, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u>						<u>U.S.N H. Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure # 434.1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>Hypertensive Cardiovascular Disease # 330</u>						Indef.	
DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-24-</u> , 19 <u>55</u> , to <u>5-1-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-1-</u> , 19 <u>55</u> , and that death occurred at <u>1145a.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>G.M. Hinkley</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>2 May 1955</u>	
G.M. HINKLEY LCDR MC USNR				M.D. <u>U.S. Naval Hospital, Annapolis, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-4-55</u>		<u>BALTIMORE NATIONAL</u>		<u>5501 FREDERICK AV. BALTO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>5/4/55</u>		<u>Wm. J. French</u>		<u>Charles S. Juler</u>			
DATE				ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>			

100-443886-100

BUREAU V. S.

MAY 4 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04251

4283

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Glenburnie</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glenburnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Drum Point Ave., S. E.</u>				STREET ADDRESS (If rural give location) <u>105 Drum Point Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>ANNE</u>		(First)		(Middle)		(Last) <u>BRAYSHAW</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>21</u> <u>1955</u>							
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 22, 1862</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Brayshaw</u>				14. MOTHER'S MAIDEN NAME <u>Julia Lacey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Glenburnie, Md.</u> <u>Mr. Thomas Brayshaw-105 Drum Point Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.2 IMMEDIATE CAUSE (A) <u>Inanition</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 19, 1954</u>, to <u>MAY 19, 1955</u>, that I last saw the deceased alive on <u>5-17-55</u>, 19<u>55</u>, and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Chas. McDonald M.D.</u>		DATE THEREOF <u>5/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Louis J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickner & Sons</u>		DATE SIGNED <u>5-21-55</u>	

CERTIFICATE OF DEATH

4-23

Reg. Dist. No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEAREST RELATIVE

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF CHURCH

19. SIGNATURE OF BURIAL PLACE

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

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BUREAU V. 3

MAY 24 1955

RECEIVED

EMORTUARY

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4284 CERTIFICATE OF DEATH

04252

Reg. Dist. No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>17 Cherry Lane</u> MARYLAND	STATE <u>Ma</u> COUNTY <u>A.A.Co</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ceder Mill Md</u>		
X TOWN <u>AA. County Cedar Hill</u> Life	STREET ADDRESS (If rural give location) <u>17 Cherry Lane</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 Cherry Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>Bertha Irine Brooks</u>		DATE OF DEATH: <u>5</u> <u>9</u> 19 <u>55</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Nov-23-1882</u>
9. AGE last birthday <u>72</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	11. BIRTHPLACE (State or foreign country): <u>AA. County</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME: <u>John Watkins</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Armstead</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Sarah L Dyer 605 Richie Hwyway</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
171X IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>			<u>6 mo.</u>
ANTECEDENT CAUSE (B) <u>Carcinoma of Cervix</u>			<u>1 year</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Myocarditis</u>			<u>3 yrs.</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-2</u> , 19 <u>48</u> , to <u>5-9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-9</u> , 19 <u>55</u> , and that death occurred at <u>4:45</u> PM, from the causes and on the date stated above.			
SIGNATURE <u>P. J. Grimaldi</u>		ADDRESS <u>4609 Gwy. Ritchie Hwyway</u>	
DATE SIGNED <u>5-12-55</u>		DATE SIGNED <u>5-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>5-12-55</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>5-12-55</u>		REGISTRAR'S SIGNATURE <u>Edw. O. Wilson</u>	
FUNERAL DIRECTOR <u>1000 Brantley</u>		ADDRESS	

CERTIFICATE OF DEATH

4260

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 CALVERT ST</u>				STREET ADDRESS (If rural give location) <u>17 CALVERT ST</u>			
3. NAME OF DECEASED (Type or Print) <u>Richard WARDell BROWN</u>				4. DATE OF DEATH <u>5</u> <u>14</u> 19 <u>55</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>		8. DATE OF BIRTH <u>6-27-1881</u>	
9. AGE last birthday <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. U.S. NAVAL CAD</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard WARDell BROWN</u>				14. MOTHER'S MAIDEN NAME <u>JANE A. DAYAGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>SPANISH AMER.</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS <u>SARAH GREEN 108 SOUTH ST. ANNAPOLIS</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
7824 IMMEDIATE CAUSE (A) <u>Cardiac Tharure</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-11-55</u> to <u>5-14-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-12-55</u> , 19 <u>55</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Am. T. Allen</u>				ADDRESS (Street, city, town, state) <u>10 Conwell St. ANNAPOLIS, Md</u>			
DATE <u>June 7, 1955</u>				DATE SIGNED <u>5-16-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>ANNAPOLIS, Md</u>	
24. REC'D BY REGISTRAR <u>Tom J. Funch</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II</u>		ADDRESS <u>108 W. WASH. ST ANNAPOLIS, Md</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

1955

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Cause of death

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial society

18. Signature of church

19. Signature of school

20. Signature of other

BUREAU V. S.

JUN 7 1955

RECEIVED

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4285

CERTIFICATE OF DEATH

04254

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u>		COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>					
TOWN <u>Glen Burnie</u>		TOWN <u>Glen Burnie</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>107 Main Ave SW</u>		STREET ADDRESS (If rural give location) <u>107 Main Ave SW</u>					
3. NAME OF DECEASED (Type or Print) <u>EDNA HELEN BRUCKMAN</u>				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>6</u> (Year) <u>55</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>August 7, 1896</u>	
				9. AGE last birthday <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u>	
						11. IF UNDER 24 HRS. Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Altoona, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Lamca</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Matthews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>213 - 20 - 5425</u>		17. INFORMANT & ADDRESS <u>John Bruckman, 107 Main Ave SW, Glen Burnie</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
174X IMMEDIATE CAUSE (A) <u>Carcinomatosis metastatic</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma uterus</u>				<u>3 1/2</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5-3</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <u>5</u> <input type="checkbox"/> <u>55</u>		21a. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> 19 <u>54</u> , to <u>MAY</u> 19 <u>55</u> , that I last saw the deceased alive on <u>5-3</u> , 19 <u>55</u> , and that death occurred at <u>7:30</u> p.m. from the causes and on the date stated above.							
SIGNATURE <u>C. McDonald</u>		M.D. <u>Eslen Burnie Md</u>		ADDRESS (Street, city, town, state) <u>Elkridge, Howard Co. Md.</u>		DATE SIGNED <u>5-6-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkridge, Howard Co. Md.</u>	
24. REC'D BY REGISTRAR <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Hurlley</u>		ADDRESS <u>Hopping and Kirkley Funeral Home</u> <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL MANNER OF DEATH

2. CAUSE OF DEATH

3. PLACE OF DEATH

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. TIME OF BIRTH

9. SEX

10. RACE

11. OCCUPATION

12. MARITAL STATUS

13. EDUCATION

14. RELIGION

15. SOCIAL CLASS

16. PREVIOUS ILLNESS

17. PREVIOUS SURGERY

18. PREVIOUS TRAUMA

19. PREVIOUS DRUGS

20. PREVIOUS ALCOHOL

21. PREVIOUS TOBACCO

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

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BUREAU V. S.

MAY 10 1955

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04255

4286

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Shodyside</u>		<u>life</u>		OR TOWN <u>Shodyside</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Leonard Hartman Bussey</u>				<u>5</u> <u>22</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Single</u>	<u>Aug. 19, 1904</u>	<u>50</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Policeman</u>		<u>AA County</u>		<u>Churchton Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Harris Bussey</u>				<u>Queenie Franklin Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>Carcinoma lung</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>Sept 21/54</u>		<u>Fibroid core, homo</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<input type="checkbox"/>		<input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>March 3, 1955</u>, to <u>May 22, 1955</u>, that I last saw the deceased alive on <u>May 19, 1955</u>, and that death occurred at <u>1:45 PM</u>, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Smith H. Wilson</u>		<u>May 5/55</u>		<u>Zurbar</u>		<u>Galesville Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>J. B. Dent</u>		<u>Bernard Hardisty</u>		<u>Galesville Md</u>	
DATE		REGISTRAR'S SIGNATURE		ADDRESS			
<u>May-25-55</u>		<u>J. B. Dent</u>		<u>Bernard Hardisty Galesville Md</u>			

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO.

1. NAME (PRINT OR TYPE)

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. PLACE OF DEATH

BUREAU V. S.

MAY 26 1955

RECEIVED

For Hospital Use

For Burial Use

RECEIVED

TO HEALTH DEPARTMENT
TO BUREAU OF VITAL STATISTICS
TO BUREAU OF PUBLIC HEALTH

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04256

4287

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>EDGEWATER</u>				TOWN <u>EDGEWATER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM A. CADLE</u>				<u>5-22-55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>1-22-1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>WATERMAN</u>			<u>COYSTER+CRABS</u>		<u>WASHINGTON D.C.</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM CADLE</u>				<u>ZORA ELLEN BAILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>SARAH C. CADLE</u> (2)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A)				<u>Carcinoma of Stomach</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 19 55</u>, to <u>5-22 19 55</u>, that I last saw the deceased alive on <u>5-21 19 55</u>, and that death occurred at <u>6:45 A</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>James R. Ina</u>				<u>Annapolis, Md 5-22-55</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-24-55</u>		<u>Edwards Chapel</u>		<u>Annapolis RFD Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 23, 1955</u>		<u>[Signature]</u>		<u>John M. Taylor Sons</u>		<u>Annapolis Md</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04257

4288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>		<u>5 years</u>		TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10</u>				<u>111 Georgia Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Annie</u> (Middle) <u>Elizabeth</u> (Last) <u>Canfield</u>				(Month) <u>5</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widow</u>	<u>February 9, 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Lightfoot</u>				<u>Adeline Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>4 no</u>		<u>none</u>		<u>Mrs Robert Campbell 111 Georgia Ave Glen Burnie, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>4222</u> IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> 19 <u>51</u> , to <u>May 16</u> 19 <u>55</u> , that I last saw the deceased alive on <u>May 11</u> 19 <u>55</u> , and that death occurred at <u>9 A.</u> M, from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Robert Campbell MD</u>		<u>Glen Burnie, Md.</u>		<u>111 Georgia Ave</u>		<u>5-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/19/55</u>		<u>Pine Grove Cemetery</u>		<u>Mt. Airy, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 18, 1955</u>		<u>L. J. DeAlba.</u>		<u>James L. Kirkley</u>		<u>Hopping & Kirkley, Glen Burnie, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 68 Years		DATE OF DEATH May 23, 1955		TIME OF DEATH 11:00 AM	
CAUSE OF DEATH Myocardial Infarction		PLACE OF BIRTH Baltimore, Md		OCCUPATION Retired	
MANNER OF DEATH Natural		MARITAL STATUS Married		EDUCATION High School	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	
SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	

BUREAU V. 2

MAY 23 1955

RECEIVED

This certificate is to be used for the purpose of recording the death of a person who has died in Maryland. It is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body. It is to be signed by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body. It is to be filed in the office of the State Department of Health, Baltimore, Maryland.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04253

4261

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MD</u> COUNTY <u>A.A.Co.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD.</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>ANNAPOLIS MD.</u>		CITY OR TOWN <u>ANNAPOLIS MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. GENERAL Hospt.</u>		STREET ADDRESS (If rural give location) <u>CARVER Hall Hotel</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOSEPH</u>		(Middle) <u>CIERI</u>		(Last)		(Year) <u>1955</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>3/9/1890</u>	
9. AGE last birthday <u>65</u> yrs.		10. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL BARBER</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VINCENT CIERI</u>				14. MOTHER'S MAIDEN NAME <u>CHIARA Bhandi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WWI</u>		17. INFORMANT & ADDRESS <u>MARY M. K. CIERI #2</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Coronary artery disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>E. Anginal Syndrome</u>				6 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5/11/55</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/18</u> , 19 <u>52</u> , to <u>5/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shultz</u>				DATE SIGNED <u>5/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>5/11/55</u>				NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
DATE THEREOF <u>5/11/55</u>				LOCATION (City, town, or county) <u>Arlington</u>			
24. REC'D BY REGISTRAR <u>May 16, 1955</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>			
REGISTRAR'S SIGNATURE <u>U. Daniel</u>				ADDRESS <u>ANNAPOLIS, MD.</u>			

CERTIFICATE OF DEATH

6884

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

NOTIFICATION

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

BUREAU V. 3

MAY 18 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04259

4262

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH - COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Maryland</i> COUNTY <i>A. A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>A. A. General</i>		STREET ADDRESS (If rural, give location) <i>108 South St.</i>	
3. NAME OF DECEASED (First) <i>Joy</i>	(Middle) <i>Renee</i>	(Last) <i>Coates</i>	4. DATE OF DEATH (Month) <i>5</i> (Day) <i>9</i> (Year) <i>1955</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>8</i>	8. DATE OF BIRTH <i>3-14-55</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday <i>7</i> yrs. If under 1 year <i>3</i> months <i>1</i> day
11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Howard L. Coates</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Tyler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No. <i>None</i>	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <i>Howard Coates, Annapolis, Md.</i>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X

Immediate cause

(a)

Brucellobacteremia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

7 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 11, 1955

9V3549V99V

J. J. French

William Reese Jr. - 108 W. Wash. St. Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 13 1955
BUREAU V. S.

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4263

CERTIFICATE OF DEATH

04260

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mayo</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ALICE E CUMMINGS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 28, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 29, 1875</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Mayo, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Collison</u>				14. MOTHER'S MAIDEN NAME <u>Eugenia Purdy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs Hilda E Morris-Daughter-same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>On this chronic Cardio Vasc. Disease?</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Terminal B. Pneumonia</u>						<u>2 days</u>	
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 27, 1955</u> , to <u>May 28, 1955</u> , that I last saw the deceased alive on <u>May 28, 1955</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Mamie H. Evans M.D.</u>				ADDRESS (Street, city, town, state) <u>Annapolis Md</u>		DATE SIGNED <u>6/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mayo, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	
DATE <u>June 1, 55</u>							

RECEIVED

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL CENTER FOR HUMAN GENETICS
10100 ROCKVILLE PIKE
BETHESDA, MARYLAND 20814
TELEPHONE (301) 251-2500
FACSIMILE (301) 251-2501
MAILING LIST

4303

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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Handwritten signature

Handwritten signature

BUREAU V. S.

RECEIVED

JUN 2

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Handwritten signature

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4289

CERTIFICATE OF DEATH

04261

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>3 yrs. 9 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Unknown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Unknown</u>			
3. NAME OF DECEASED (Type or Print) <u>Abednego Davis</u>				4. DATE OF DEATH <u>5 4 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/2/74</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Lloyd Davis</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
451X IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis-Multiple Myocardial Infarctions</u>						Known to us 1/5/54	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Aortic Aneurysm</u>						Known to us since 7/24/51	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General Paresis</u>						Known to us since 7/21/51	
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>7/21/51</u> , 19 <u>51</u> , to <u>5/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/4</u> , 19 <u>55</u> , and that death occurred at <u>6:45a</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Stanley P. Sargant</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>5/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 5, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hall's Main Church Cemetery A. C. Co.</u>		LOCATION (City, town, or county) (State) <u>A. C. Co. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>May 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Katherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Salter</u>		ADDRESS <u>1011 N. ...</u>	

CERTIFICATE OF DEATH

4329

Reg. Dist. No. 1

1. Name of deceased (Print or write)

2. Date of death

3. Time of death

4. Place of death

5. Name of physician

6. Name of hospital

7. Name of attending physician

8. Name of medical examiner

9. Name of registrar

10. Sex

11. Age

12. Race

13. Birth date

14. Birth place

15. Cause of death

16. Immediate cause

17. Underlying cause

18. Contributing cause

19. Name of hospital

20. Name of medical examiner

21. Name of registrar

22. Name of registrar

23. Name of registrar

24. Name of registrar

25. Name of registrar

26. Name of registrar

BUREAU V. S.

MAY 9 1955

RECEIVED

ENCLOSURE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT, AND IT IS TO BE DESTROYED AFTER THE EXPIRATION OF THE FIFTY YEAR PERIOD.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4290

CERTIFICATE OF DEATH

04262

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>2 1/2</u> years		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital, Md.</u>				STREET ADDRESS (If rural give location) <u>2415 Terra Firma Road</u> ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Wayne</u>		(Middle) <u>Tyrone</u>		(Last) <u>Davis</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>1938</u>	9. AGE last birthday <u>17</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Davis</u>				14. MOTHER'S MAIDEN NAME <u>Lillie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Crownsville State Hospital, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>351+</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>-----</u>		19b. MAJOR FINDINGS OF OPERATION <u>-----</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-----</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-----</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-----</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-----</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 13</u> , 19 <u>52</u> , to <u>May 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/18</u> , 19 <u>55</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>5/19/55</u>			
M. D. <u>-----</u>				ADDRESS (Street, city, town, or county) <u>Crownsville State Hospital, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>-----</u>		DATE THEREOF <u>5/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>mt Auburn</u>		LOCATION (City, town, or county) (State) <u>Baltimore city md.</u>	
24. REC'D BY REGISTRAR DATE <u>May 19 '55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			
				ADDRESS <u>578 W. St. Bridge</u>			

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

04263

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 12, File 181 5-20-55 et

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
TOWN <u>ANNAPOLIS</u>		TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 DUKE OF GLOUCESTER</u>		STREET ADDRESS (If rural, give location) <u>82 DUKE OF GLOUCESTER</u>	
3. NAME OF DECEASED (Type or Print) <u>THOMAS ROSZELLE DAWSON</u>		4. DATE OF DEATH <u>MAY 12 1955</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>3-13-1887</u>	
9. AGE last birthday <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONCESSIONER</u>	
11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE HENRY DAWSON</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY No. <u>W.W.I.</u>	
17. INFORMANT AND ADDRESS <u>MRS. THOMAS R. DAWSON</u>		(same address)	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>10 minutes</u>	
(a) <u>Cerebral hemorrhage</u>			
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 3-31, 1955, to 5-12, 1955, that I last saw the deceasedalive on 5-6, 1955, and that death occurred at 8:30 A m., from the causes and on the date stated above.SIGNATURE Gene L. Wilkins M.D. (Degree or title) ADDRESS 232 Prince George St. Annapolis Md. DATE SIGNED 5/12/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>5-14-55</u>	<u>Christ Church</u>	<u>Cambridge</u>	<u>Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRATION SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 14, 1955</u>	<u>J. O. Daniel</u>	<u>John M. Taylor Sons</u>	<u>Annapolis Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 18 1935

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04264

4265

CERTIFICATE OF DEATH

Item 12, Film G182 5-31-55 et

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundell</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		1 day		OR TOWN <u>Edgewater</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
63 <u>Anne Arundell General</u>				County Home			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANZ</u> (Middle) <u>DEIN</u> (Last)				(Month) <u>May</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W	widowed	April 10 1870	85 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Seaman					Germany		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
unk		unk		County Home Records, Edgewater Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A)				<u>Hypertensive Cardiovascular Disease</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Fracture Femur Right</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
1 5/9/55		<u>Fracture Femur</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>		<u>County Home</u>		<u>02</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
5 9 55 P. M.		White <input type="checkbox"/> Not white <input checked="" type="checkbox"/>		<u>Fell at County Home</u>			
22. I hereby certify that I attended the deceased from <u>5-9-55</u> , 19 <u>55</u> , to <u>5-10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-10</u> , 19 <u>55</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. Reinhardt</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>Annapolis, Maryland</u>		<u>5/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Buried</u>		<u>5/13/55</u>		<u>County Home</u>		<u>Edgewater Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 16, 1955</u>		<u>J. J. Towell</u>		<u>Bernard Hardisty, Silverville Md</u>			

CERTIFICATE OF DEATH

4368

Reg. Dist. No.

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. PLACE OF BIRTH

7. OCCUPATION

8. MANNER OF DEATH

9. SEX AND AGE

10. MEDICAL CERTIFICATION

11. DATE OF BIRTH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF COURT

18. SIGNATURE OF STATE

19. SIGNATURE OF COUNTY

20. SIGNATURE OF CITY

21. SIGNATURE OF TOWN

22. SIGNATURE OF VILLAGE

23. SIGNATURE OF POST OFFICE

24. SIGNATURE OF SCHOOL

25. SIGNATURE OF CHURCH

26. SIGNATURE OF SYNAGOGUE

27. SIGNATURE OF MOSQUE

28. SIGNATURE OF TEMPLE

29. SIGNATURE OF MONASTERY

30. SIGNATURE OF CONVENT

31. SIGNATURE OF NUNNERY

32. SIGNATURE OF PRIORY

33. SIGNATURE OF ABBEY

34. SIGNATURE OF BISHOPRIC

35. SIGNATURE OF ARCHBISHOPRIC

RECEIVED

OFFICE OF THE STATE DEPARTMENT OF HEALTH - BALTIMORE

RECEIVED MAY 18 1955

EAU V. A.

MAY 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4266

CERTIFICATE OF DEATH

04265

Reg. Dist. No. 29

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u>		COUNTY <u>Anne Arundel</u>			
CITY OR TOWN <u>10 Annapolis MD.</u>		CITY OR TOWN <u>Shore Acres MDX</u>		CITY OR TOWN <u>Shore Acres MDX</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 Anne Arundel General Hospital</u>		STREET ADDRESS <u>MAGOTHY AVE.</u>		STREET ADDRESS <u>MAGOTHY AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Derschinger</u>				4. DATE OF DEATH <u>MAY 24 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)		8. DATE OF BIRTH <u>Nov 10. 1876</u>	
9. AGE last birthday <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles Bohle</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Deist</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Husband Charles Derschinger Shore Acres Md</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Insufficiency</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5/24/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 April 55</u> to <u>24 May 55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24 May 55</u> , and that death occurred at <u>5:24 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Halun</u>				ADDRESS <u>Severna Park Md</u>			
DATE <u>5/28/55</u>				DATE SIGNED <u>24 May 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>A.A. Co., Md.</u>	
24. REC'D BY REGISTRAR <u>May 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tichner</u>		ADDRESS <u>Shore Acres Md</u>	

CERTIFICATE OF DEATH

Form 100-100

IN ALL INFORMATION MORE OF WHICH

NAME OF DECEASED: *John A. Smith*
DATE OF DEATH: *May 28, 1955*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*

AGE: *65*
SEX: *Male*
RACE: *White*
BIRTH DATE: *May 28, 1955*

EDUCATION: *High School*
OCCUPATION: *Teacher*
MARRIAGE: *Married*

PREVIOUS ILLNESS: *None*
HISTORY OF DRUGS: *None*
HISTORY OF ALCOHOL: *None*

BUREAU V. S.

MAY 27 1955

RECEIVED

INSTRUCTIONS

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04266

4291 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Louisiana</u>		COUNTY <u>Iberville Parish</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>		LENGTH OF STAY (in this place) DOA		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Plaquemine</u>		<u>56 X - 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>USNH, Annapolis, Maryland</u>				STREET ADDRESS (If rural give location) <u>R.R.D. #1</u>			
3. NAME OF DECEASED (Type or Print) <u>FOURROUX John Donald FOURROUX</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>March 2, 1930</u>	9. AGE last birthday <u>25</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ivan P. Fourroux</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Navy records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>INJURIES, MULTIPLE, EXTREME #869</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Rt-301 Anne Arundel County Maryland</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 31, 1955 2:25A M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR? <u>Automobile collision</u>			
22. I hereby certify that I attended the deceased from <u>19</u> , <u>19</u> , <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:25A M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. H. BROWN, LCDR, MC, USN</u>				DATE SIGNED <u>M.D. U.S. Naval Hospital, Annapolis, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>June 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>to</u>		LOCATION (City, town, or county) (State) <u>Plaquemine, Louisiana</u>	
24. REC'D BY REGISTRAR DATE <u>June 2, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>			

4292 CERTIFICATE OF DEATH

04267

Reg. Dist. No. 27

INSTRUCTIONS

1 The law requires that the death certificate be executed within 24 hours after death.

2 The bottom copy may be retained by the hospital or attending physician.

3 The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Pennsylvania</u> COUNTY <u>Allegheny</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>6 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>		STREET ADDRESS (If rural give location) <u>3501 Old Orchard Circle</u>					
3. NAME OF DECEASED (Type or Print) <u>Infant Girl</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 19 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>19 May 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		9. AGE last birthday <u>4</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Alexander Fredland</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Regina Schaldenbrand</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father</u> <u>2012 N. Calvert St., Baltimore, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>762.5 IMMEDIATE CAUSE (A) <u>ATZKETASIS</u></u>				<u>14 hrs</u>			
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Prematurity</u>							
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DUE TO (C)							
19a. DATE OF OPERATION <u>20</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>19 May 1955 9:50 P.M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 May 1955</u> , to <u>19 May 1955</u> , that I last saw the deceased alive on <u>19 May 1955</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Herbert L. Zessedeman M.D.</u>				ADDRESS (Street, city, town, state) <u>Fort Meade A.H.</u>			
DATE SIGNED <u>19 May 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pittsburgh, Pennsylvania</u>	
24. REC'D BY REGISTRAR <u>20 May 1955</u>		REGISTRAR'S SIGNATURE <u>A. J. COMBOSH, CAPT. MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK</u>		ADDRESS <u>Baltimore, Maryland</u>	

2055210322

RECEIVED

NOTICE: This is a notice to the public that the State of Maryland has received a report of a death. The report was received from the local health officer of the county in which the death occurred. The report was received on May 24, 1965. The death occurred on May 23, 1965. The deceased was a male, white, born on May 10, 1910, in Baltimore, Maryland. He was a resident of Baltimore, Maryland. He died of a heart attack. The cause of death was atherosclerosis of the heart. The death was reported to the local health officer by the attending physician. The local health officer has filed the report with the State Department of Health. The State Department of Health has received the report and is processing it. The report will be made available to the public upon request.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Dist. No.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. AGE

6. DATE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. CAUSE OF DEATH

13. MANNER OF DEATH

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF NEXT OF KIN

19. SIGNATURE OF CLERK

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CORONER

24. SIGNATURE OF DISTRICT ATTORNEY

25. SIGNATURE OF COUNTY CLERK

26. SIGNATURE OF STATE CLERK

27. SIGNATURE OF U.S. DEPT. OF HEALTH

28. SIGNATURE OF U.S. DEPT. OF JUSTICE

29. SIGNATURE OF U.S. DEPT. OF AGRICULTURE

30. SIGNATURE OF U.S. DEPT. OF COMMERCE

31. SIGNATURE OF U.S. DEPT. OF EDUCATION

32. SIGNATURE OF U.S. DEPT. OF INTERIOR

33. SIGNATURE OF U.S. DEPT. OF LABOR

34. SIGNATURE OF U.S. DEPT. OF NAVY

35. SIGNATURE OF U.S. DEPT. OF STATE

36. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION

37. SIGNATURE OF U.S. DEPT. OF WAR

38. SIGNATURE OF U.S. DEPT. OF DEFENSE

39. SIGNATURE OF U.S. DEPT. OF ENERGY

40. SIGNATURE OF U.S. DEPT. OF ENVIRONMENT

41. SIGNATURE OF U.S. DEPT. OF HEALTH AND HUMAN SERVICES

42. SIGNATURE OF U.S. DEPT. OF AGRICULTURE

43. SIGNATURE OF U.S. DEPT. OF COMMERCE

44. SIGNATURE OF U.S. DEPT. OF JUSTICE

45. SIGNATURE OF U.S. DEPT. OF EDUCATION

46. SIGNATURE OF U.S. DEPT. OF INTERIOR

47. SIGNATURE OF U.S. DEPT. OF LABOR

48. SIGNATURE OF U.S. DEPT. OF NAVY

49. SIGNATURE OF U.S. DEPT. OF STATE

50. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION

BUREAU V. S.

MAY 24 1965

RECEIVED

CERTIFICATE OF DEATH

04268

Reg. Dist. No. 21

4267

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Penn</u>		COUNTY <u>Alleghany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Annapolis</u>		LENGTH OF STAY (in this place) DOA		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pittsburgh</u>		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>7 Whitman</u>			
3. NAME OF DECEASED (Type or Print) <u>James A GELSTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 17 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>2-20-37</u>	9. AGE last birthday <u>18</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>USN</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Patrick GELSTON</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes active duty</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>USNH Records</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
825X IMMEDIATE CAUSE (A) <u>Injuries, Internal, multiple extreme # 869</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Highway</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Rural-Annapolis AA MD</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 17 55 M.</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR? <u>Automobile Accident</u>			
22. I hereby certify that I attended the deceased from <u>5-17</u> , 19 <u>55</u> , to <u>5-17</u> , 19 <u>55</u> , that I last saw the deceased <u>alive or DOA</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>G.M. HIMADI LCDR MC USNR</u>				DATE SIGNED <u>U.S. Naval Hospital, Annapolis, Md. 18 May 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>May 18 1955</u>		NAME OF CEMETERY OR CREMATORY <u>to</u>		LOCATION (City, town, or county) (State) <u>Pittsburgh, Pa.</u>	
24. REC'D BY REGISTRAR <u>May 18, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

21

ATTEST: I hereby certify that the foregoing is a true and correct copy of the original as filed in my office.

WITNESSED my hand and the seal of the Department of Health at Albany, New York, this 10th day of May, 1955.

JOHN J. HENRICH, Jr.,
Commissioner of Health

JOHN J. HENRICH, Jr.,
Commissioner of Health

22

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X

BUREAU V. S.

1-1-

X

17-MAY 30 1955

2

2-2

RECEIVED

MAY 13 1955

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4268

CERTIFICATE OF DEATH

04263

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>Waugh Chapel Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>EDGAR</u>		(Middle) <u>R</u>		(Last) <u>GEORGE</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 12, 1884</u>	
				9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William E. George</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>214-22-8047</u>		17. INFORMANT & ADDRESS <u>Mrs Mary M. George- Wife- same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchiectasis</u>						15 yrs.	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 20</u> , 19 <u>55</u> , to <u>May 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>55</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Richard G. Hopping</u> M.D. <u>4268-1115</u> DATE SIGNED <u>5-31-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Waugh Chapel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Odenton, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 1, 55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH Baltimore, Md.		5. OCCUPATION Teacher		6. MARITAL STATUS Married	
7. DATE OF DEATH June 2, 1965		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF DECEASED [Signature]	

BUREAU V. 2

JUN 2 1965

RECEIVED

NOTICE: This certificate is valid only if it is filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. If it is not so filed, it is invalid for all legal purposes.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4269

CERTIFICATE OF DEATH

04270

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10. TOWN <u>ANNAPOLIS</u>				TOWN <u>Millersville, Md.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
63. <u>ANNE ARUNDEL</u>		<u>Sen.</u>					
3. NAME OF DECEASED				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>LUCY</u>				OF DEATH <u>5</u> <u>8</u> 19 <u>55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>colored</u>		<u>Widowed</u>		<u>8-27-1884</u>	
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>70</u> yrs.		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				<u>None</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Chapman</u>				<u>Julia Garrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>4 No</u>				<u>None</u>			
17. INFORMANT & ADDRESS							
<u>EVA THOMAS</u>				<u>Millersville, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
434.1 IMMEDIATE CAUSE (A)				<u>has Cardiac Failure</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>Oscar H MacNamer, M.D.</u>				ADDRESS (Street, city, town, state) <u>Millersville, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-11-55</u>		<u>John Wesley</u>		<u>Waterbury, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 11, 1955</u>		<u>J. J. O'Donoghue</u>		<u>William Bassett</u>		<u>108202 Washington St. ANNAPOLIS, Maryland</u>	

CERTIFICATE OF DEATH

1. Name of deceased: *John William Smith*

2. Sex: *Male*

3. Date of birth: *Jan 15, 1900*

4. Place of birth: *St. Louis, Mo.*

5. Race: *White*

6. Occupation: *Engineer*

7. Usual residence: *1234 N. Main St., Baltimore, Md.*

8. Date of death: *May 10, 1955*

9. Time of death: *10:30 AM*

10. Cause of death: *Myocardial infarction*

11. Place of death: *Home*

12. Signature of physician: *Dr. J. H. Jones*

13. Signature of registrar: *John A. Smith*

14. Signature of informant: *John A. Smith*

15. Signature of funeral director: *John A. Smith*

16. Signature of undertaker: *John A. Smith*

17. Signature of coroner: *John A. Smith*

18. Signature of health officer: *John A. Smith*

19. Signature of medical examiner: *John A. Smith*

20. Signature of pathologist: *John A. Smith*

21. Signature of anatomist: *John A. Smith*

22. Signature of bacteriologist: *John A. Smith*

23. Signature of virologist: *John A. Smith*

24. Signature of parasitologist: *John A. Smith*

25. Signature of epidemiologist: *John A. Smith*

26. Signature of public health nurse: *John A. Smith*

27. Signature of health department: *John A. Smith*

28. Signature of health department: *John A. Smith*

29. Signature of health department: *John A. Smith*

30. Signature of health department: *John A. Smith*

31. Signature of health department: *John A. Smith*

32. Signature of health department: *John A. Smith*

33. Signature of health department: *John A. Smith*

34. Signature of health department: *John A. Smith*

35. Signature of health department: *John A. Smith*

36. Signature of health department: *John A. Smith*

37. Signature of health department: *John A. Smith*

38. Signature of health department: *John A. Smith*

39. Signature of health department: *John A. Smith*

40. Signature of health department: *John A. Smith*

41. Signature of health department: *John A. Smith*

42. Signature of health department: *John A. Smith*

43. Signature of health department: *John A. Smith*

44. Signature of health department: *John A. Smith*

45. Signature of health department: *John A. Smith*

46. Signature of health department: *John A. Smith*

47. Signature of health department: *John A. Smith*

48. Signature of health department: *John A. Smith*

49. Signature of health department: *John A. Smith*

50. Signature of health department: *John A. Smith*

51. Signature of health department: *John A. Smith*

52. Signature of health department: *John A. Smith*

53. Signature of health department: *John A. Smith*

54. Signature of health department: *John A. Smith*

55. Signature of health department: *John A. Smith*

56. Signature of health department: *John A. Smith*

57. Signature of health department: *John A. Smith*

58. Signature of health department: *John A. Smith*

59. Signature of health department: *John A. Smith*

60. Signature of health department: *John A. Smith*

61. Signature of health department: *John A. Smith*

62. Signature of health department: *John A. Smith*

63. Signature of health department: *John A. Smith*

64. Signature of health department: *John A. Smith*

65. Signature of health department: *John A. Smith*

BUREAU V. 2

MAY 13 1955

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04271

4293

CERTIFICATE OF DEATH

Items 13, 14, Film G182 6-3-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>aa</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>aa</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>X</i> TOWN <i>Tracy</i>		<i>4 yrs</i>		TOWN <i>Tracy</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>60</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Susie</i> <i>Hall</i>				<i>May 9</i> <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>F</i>	<i>C</i>	<i>widow</i>	<i>DEC 15 1896</i>	<i>58</i> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Domestic</i>				<i>AA Co MD</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Unknown</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>Yes</i>		<i>—</i>		<i>Catherine Hall 47 Calver St. Annapolis</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<i>420.1</i>						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)						<i>15 min</i>	
ANTECEDENT CAUSE(S) DUE TO						<i>24 hrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<i>unk</i>	
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<i>Coronary Thrombosis</i>							
<i>Myocardial Fibillation</i>							
<i>Hypertensive CV Disease</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<i>0</i>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?	
				While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <i>1945</i>, 19 <i>55</i>, to <i>May 9, 55</i>, that I last saw the deceased alive on <i>9 May</i>, 19 <i>55</i>, and that death occurred at <i>10 P</i>. M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>RR3 Darcce</i>				<i>Hypermarco Ind</i>		<i>11 May 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>Burne</i>				<i>Union Chapel</i>		<i>McKendree Ind</i>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<i>DATE May 11, 1955</i>				<i>Essi West Williams</i>		<i>Bernard Hardisty</i>	

CERTIFICATE OF DEATH

REG. DIST. NO.

SIGNATURE OF DECEASED

John

Thompson

MARYLAND

Thompson

John

Thompson

DATE OF DEATH

June

June

1890

MD

MD

John Thompson

BUREAU V. S.

MAY 16 1955

RECEIVED

109

John Thompson

John Thompson

NOTARY PUBLIC

STATE OF MARYLAND, COUNTY OF BALTIMORE, I, the undersigned, a Notary Public in and for said County, do hereby certify that the foregoing is a true and correct copy of the original of the Certificate of Death of the above named deceased, as the same appears from the records of the State Department of Health, Baltimore, Maryland.

WITNESSED my hand and the seal of my office this 16th day of May, 1955.

4294

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

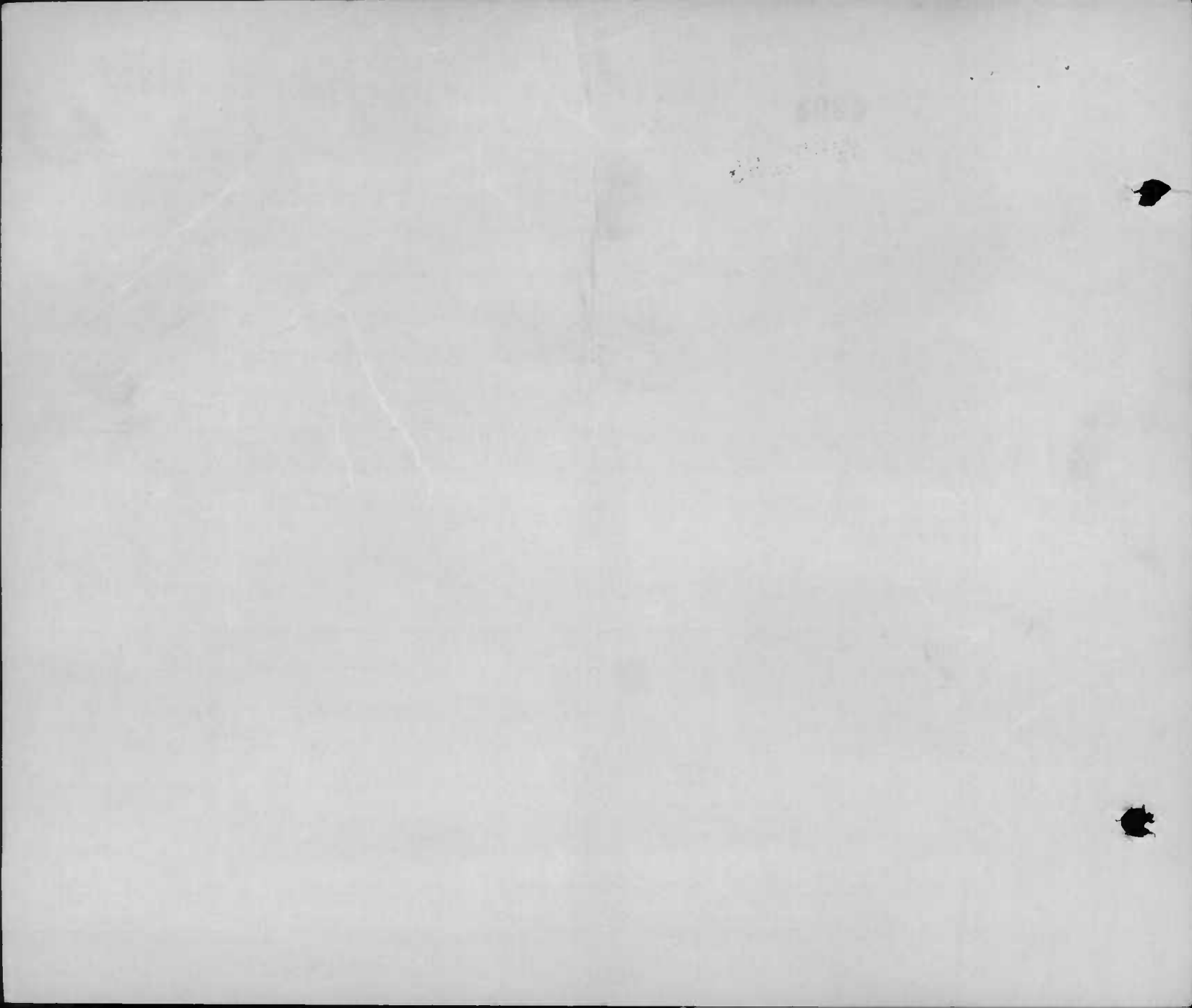
04272

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brooklyn Park</u> LENGTH OF STAY (In this place) <u>15 minutes</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 301-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Arundel Sand Beach, Md.</u>				STREET ADDRESS (If rural, give location) <u>1331-14th St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>James Daniel Randy</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 24 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>		8. DATE OF BIRTH <u>12/29/33</u>	
9. AGE last birthday <u>21</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proctor's shoe clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>A.A.</u>				13. FATHER'S NAME <u>William R. Randy</u>			
14. MOTHER'S MAIDEN NAME <u>Ellen Lee</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes, 1950</u>			
16. SOCIAL SECURITY NO. <u>215-20-1262</u>				17. INFORMANT AND ADDRESS <u>Wm. Randy (father)</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
929.8 Immediate cause (a) <u>Accidental Drowning</u> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last _____ (c) _____						<u>sudden</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Body of water</u> (CITY OR TOWN) <u>Brooklyn</u> (COUNTY) <u>A.A.</u> (STATE) <u>Md.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/24/55 6:30 P. m.</u>				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Drowning</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>Walter X Paulus MD. Deputy Medical Examiner</u>				ADDRESS <u>1348 N. Calhoun St.</u>			
DATE SIGNED <u>5/25/55</u>							
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 27, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Balto nat</u>		LOCATION (City, town, or county) (State) <u>and</u>	
DATE REC'D BY LOCAL REG. <u>8-26-55</u>		REGISTRAR'S SIGNATURE <u>Dr. H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>George S. Nelson</u>		ADDRESS <u>1348 N. Calhoun St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4295

CERTIFICATE OF DEATH

04273

Reg. Dist. No. 28

Item 22 Film G181 5-19-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE Maryland		COUNTY Cecil			
CITY OR TOWN Crownsville		LENGTH OF STAY (in this place) 1 yr. 6 mos. 19 days		CITY OR TOWN Cecilton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS Box 32			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Eva		(Middle) May		(Last) Harris			
5. SEX Female		6. COLOR OR RACE Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 10/4/86	
9. AGE last birthday 68 yrs.		10. IF UNDER 1 YEAR 5 Months 16 Days		11. IF UNDER 24 HRS. 19 Hours 55 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Absolom Greenby				14. MOTHER'S MAIDEN NAME Hester A. Gunby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 434.3 Cardiac Arrest							
ANTECEDENT CAUSE(S) DUE TO (B) Emaciation of long standing							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/23/53 , 19 55 , to 5/16 , 19 55 , that I last saw the deceased alive on 5/16 , 19 55 , and that death occurred at 12:20 M, from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 5/16/55	
23. BURIAL, CREMATION REMOVAL (SPECIFY) Buried		DATE THEREOF May 19, 1955		NAME OF CEMETERY OR CREMATORY Cecilton Cem.		LOCATION (City, town, or county) (State) Cecilton Md.	
24. REC'D BY REGISTRAR 5-16-55		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS	

5542

BUREAU V. S.

1975 18 MAY

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4296 Items 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 5-16-55 et
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 26

04274
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Fair Haven</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Fair Haven</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>William</u> (Middle) <u>Irish</u> (Last) <u>Herbert</u>		5. (Month) <u>5</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>11-1-79</u>
9. AGE last birthday: <u>75</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Type setter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>U. S. Gov.</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>James Herbert</u>		14. MOTHER'S MAIDEN NAME: <u>Julia Cannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>Spanish American</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Cornary artery occlusion</u> DUE TO Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Emily H. Hulm, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-10-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial - General</u>	DATE THEREOF <u>May 13, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>
LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	DATE REC'D BY LOCAL REG. <u>May 10-55</u>	REGISTRAR'S SIGNATURE <u>D. B. Dent</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>Silver Spring Md.</u>

BUREAU V. 2

MAY 12 1955

RECEIVED

4270

CERTIFICATE OF DEATH

04275

Reg. Dist. No. 21

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH COUNTY <u>ANNAPOLIS</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> TOWN <u>ANNAPOLIS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ann Arundel Gen. Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>AA</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> OR TOWN <u>Edgewater</u> STREET ADDRESS (If rural give location) <u>Woodland Beach</u>			
3. NAME OF DECEASED (Type or Print) <u>Jeanette</u> (First) <u>Hoet</u> (Middle) (Last) 4. DATE OF DEATH <u>May 21</u> 19 <u>55</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u> 8. DATE OF BIRTH <u>Dec 30 - 1890</u> 9. AGE last birthday <u>64</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Alex. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Sriefuss</u>				14. MOTHER'S MAIDEN NAME <u>Hellie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Cecil Boswell Woodland Beach</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>coronary heart disease</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>arterosclerotic heartdis.</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>hypertension, ca. arterioscl.</u> STATING UNDERLYING CAUSE LAST. <u>8 years</u>						19. DATE OF OPERATION <u>0</u> 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 15</u> , 19 <u>47</u> , to <u>May 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 22</u> , 19 <u>55</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edith Rollier</u> M.D. <u>45 Franklin St. Annapolis</u>				ADDRESS (Street, city, town, state) <u>5-22-55</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/18/55</u>		NAME OF CEMETERY, OR CREMATORY <u>Arlington Natl.</u>		LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
24. REC'D BY REGISTRAR <u>May 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>		ADDRESS <u>Co 517 11th St SE</u>	

CERTIFICATE OF DEATH

4870

1. PLACE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 CITY
 STATE
 COUNTRY

2. CAUSE OF DEATH

IMMEDIATE
 UNDERLYING
 REMOTE

3. PLACE OF DEATH
 NAME OF PLACE
 STREET
 CITY
 STATE
 COUNTRY

4. DATE OF DEATH

5. TIME OF DEATH

6. SEX

7. AGE

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. RACE

12. RELIGION

13. BIRTH DATE

14. BIRTH PLACE

15. BIRTH COUNTRY

16. BIRTH STATE

17. BIRTH CITY

18. BIRTH STREET

19. BIRTH ZIP

20. BIRTH COUNTY

21. BIRTH STATE

22. BIRTH COUNTRY

23. BIRTH DATE

24. BIRTH PLACE

25. BIRTH COUNTRY

26. BIRTH STATE

27. BIRTH CITY

28. BIRTH STREET

29. BIRTH ZIP

30. BIRTH COUNTY

31. BIRTH STATE

32. BIRTH COUNTRY

33. BIRTH DATE

34. BIRTH PLACE

35. BIRTH COUNTRY

36. BIRTH STATE

37. BIRTH CITY

38. BIRTH STREET

39. BIRTH ZIP

40. BIRTH COUNTY

41. BIRTH STATE

42. BIRTH COUNTRY

43. BIRTH DATE

44. BIRTH PLACE

45. BIRTH COUNTRY

46. BIRTH STATE

47. BIRTH CITY

48. BIRTH STREET

49. BIRTH ZIP

50. BIRTH COUNTY

51. BIRTH STATE

52. BIRTH COUNTRY

53. BIRTH DATE

54. BIRTH PLACE

55. BIRTH COUNTRY

56. BIRTH STATE

57. BIRTH CITY

58. BIRTH STREET

59. BIRTH ZIP

60. BIRTH COUNTY

61. BIRTH STATE

62. BIRTH COUNTRY

63. BIRTH DATE

64. BIRTH PLACE

65. BIRTH COUNTRY

66. BIRTH STATE

67. BIRTH CITY

68. BIRTH STREET

69. BIRTH ZIP

70. BIRTH COUNTY

71. BIRTH STATE

72. BIRTH COUNTRY

73. BIRTH DATE

74. BIRTH PLACE

75. BIRTH COUNTRY

76. BIRTH STATE

77. BIRTH CITY

78. BIRTH STREET

79. BIRTH ZIP

80. BIRTH COUNTY

81. BIRTH STATE

82. BIRTH COUNTRY

83. BIRTH DATE

84. BIRTH PLACE

85. BIRTH COUNTRY

86. BIRTH STATE

87. BIRTH CITY

88. BIRTH STREET

89. BIRTH ZIP

90. BIRTH COUNTY

91. BIRTH STATE

92. BIRTH COUNTRY

93. BIRTH DATE

94. BIRTH PLACE

95. BIRTH COUNTRY

96. BIRTH STATE

97. BIRTH CITY

98. BIRTH STREET

99. BIRTH ZIP

100. BIRTH COUNTY

101. BIRTH STATE

102. BIRTH COUNTRY

103. BIRTH DATE

104. BIRTH PLACE

105. BIRTH COUNTRY

106. BIRTH STATE

107. BIRTH CITY

108. BIRTH STREET

109. BIRTH ZIP

110. BIRTH COUNTY

111. BIRTH STATE

112. BIRTH COUNTRY

113. BIRTH DATE

114. BIRTH PLACE

115. BIRTH COUNTRY

116. BIRTH STATE

117. BIRTH CITY

118. BIRTH STREET

119. BIRTH ZIP

120. BIRTH COUNTY

121. BIRTH STATE

122. BIRTH COUNTRY

123. BIRTH DATE

124. BIRTH PLACE

125. BIRTH COUNTRY

126. BIRTH STATE

127. BIRTH CITY

128. BIRTH STREET

129. BIRTH ZIP

130. BIRTH COUNTY

131. BIRTH STATE

132. BIRTH COUNTRY

133. BIRTH DATE

134. BIRTH PLACE

135. BIRTH COUNTRY

136. BIRTH STATE

137. BIRTH CITY

138. BIRTH STREET

139. BIRTH ZIP

140. BIRTH COUNTY

141. BIRTH STATE

142. BIRTH COUNTRY

143. BIRTH DATE

144. BIRTH PLACE

145. BIRTH COUNTRY

146. BIRTH STATE

147. BIRTH CITY

148. BIRTH STREET

149. BIRTH ZIP

150. BIRTH COUNTY

151. BIRTH STATE

152. BIRTH COUNTRY

153. BIRTH DATE

154. BIRTH PLACE

155. BIRTH COUNTRY

156. BIRTH STATE

157. BIRTH CITY

158. BIRTH STREET

159. BIRTH ZIP

160. BIRTH COUNTY

161. BIRTH STATE

162. BIRTH COUNTRY

163. BIRTH DATE

164. BIRTH PLACE

165. BIRTH COUNTRY

166. BIRTH STATE

167. BIRTH CITY

168. BIRTH STREET

169. BIRTH ZIP

170. BIRTH COUNTY

171. BIRTH STATE

172. BIRTH COUNTRY

173. BIRTH DATE

174. BIRTH PLACE

175. BIRTH COUNTRY

176. BIRTH STATE

177. BIRTH CITY

178. BIRTH STREET

179. BIRTH ZIP

180. BIRTH COUNTY

181. BIRTH STATE

182. BIRTH COUNTRY

183. BIRTH DATE

184. BIRTH PLACE

185. BIRTH COUNTRY

186. BIRTH STATE

187. BIRTH CITY

188. BIRTH STREET

189. BIRTH ZIP

190. BIRTH COUNTY

191. BIRTH STATE

192. BIRTH COUNTRY

193. BIRTH DATE

194. BIRTH PLACE

195. BIRTH COUNTRY

196. BIRTH STATE

197. BIRTH CITY

198. BIRTH STREET

199. BIRTH ZIP

200. BIRTH COUNTY

201. BIRTH STATE

202. BIRTH COUNTRY

203. BIRTH DATE

204. BIRTH PLACE

205. BIRTH COUNTRY

206. BIRTH STATE

207. BIRTH CITY

208. BIRTH STREET

209. BIRTH ZIP

210. BIRTH COUNTY

211. BIRTH STATE

212. BIRTH COUNTRY

213. BIRTH DATE

214. BIRTH PLACE

215. BIRTH COUNTRY

216. BIRTH STATE

217. BIRTH CITY

218. BIRTH STREET

219. BIRTH ZIP

220. BIRTH COUNTY

221. BIRTH STATE

222. BIRTH COUNTRY

223. BIRTH DATE

224. BIRTH PLACE

225. BIRTH COUNTRY

226. BIRTH STATE

227. BIRTH CITY

228. BIRTH STREET

229. BIRTH ZIP

230. BIRTH COUNTY

231. BIRTH STATE

232. BIRTH COUNTRY

233. BIRTH DATE

234. BIRTH PLACE

235. BIRTH COUNTRY

236. BIRTH STATE

237. BIRTH CITY

238. BIRTH STREET

239. BIRTH ZIP

240. BIRTH COUNTY

241. BIRTH STATE

242. BIRTH COUNTRY

243. BIRTH DATE

244. BIRTH PLACE

245. BIRTH COUNTRY

246. BIRTH STATE

247. BIRTH CITY

248. BIRTH STREET

249. BIRTH ZIP

250. BIRTH COUNTY

251. BIRTH STATE

252. BIRTH COUNTRY

253. BIRTH DATE

254. BIRTH PLACE

255. BIRTH COUNTRY

256. BIRTH STATE

257. BIRTH CITY

258. BIRTH STREET

259. BIRTH ZIP

260. BIRTH COUNTY

261. BIRTH STATE

262. BIRTH COUNTRY

263. BIRTH DATE

264. BIRTH PLACE

265. BIRTH COUNTRY

266. B

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04276

4271

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place) <u>28</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Eastport</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>51</u> <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>1019 Tyler Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Etta</u> <u>B</u> <u>HOWARD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>2</u> <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>7-29-82</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Hezekiah BOWEN</u>				14. MOTHER'S MAIDEN NAME <u>Edith HARDESTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>USNH Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>586X</u> <u>MYOCARDIAL FAILURE ACUTE NOS 782.4</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>OBSTRUCTION COMMON BILE DUCT NOS 586</u>						10 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 March</u> , 19 <u>55</u> , to <u>2 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2 May</u> , 19 <u>55</u> , and that death occurred at <u>9:55P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>P. O. Geib</u> P. O. GEIB, LCDR, MC, USN.				ADDRESS (Street, city, town, state) DATE SIGNED M. D. U.S. Naval Hospital, Annapolis, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/5/55</u>		NAME OF GEMETERY OR CREMATORY <u>Ashbury Methodist</u>		LOCATION (City, town, or county) (State) <u>Barstow, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>May 5, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John M. Layton & Sons Annapolis, Md.</u>			

1
 I hereby certify that the following is a true and correct copy of the original as the same appears in the records of the Bureau of Health Statistics of the State of Maryland.
 In witness whereof, I have hereunto set my hand and the seal of the Bureau at Baltimore, Maryland, this 1st day of May, 1955.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

PLACE OF DEATH _____		COUNTY _____	
NAME OF DECEASED _____		SEX _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF BIRTH _____		AGE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	

BUREAU V. 2

MAY 29 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4297

CERTIFICATE OF DEATH

04277

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>	
CITY OR TOWN <u>RURAL - Glen Burnie</u>		LENGTH OF STAY (in this place) <u>13 yrs.</u>		CITY OR TOWN <u>RURAL - Glen Burnie, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rfd #1 - Severn P.O. Md</u>				STREET ADDRESS (If rural give location) <u>Rfd #1 - Severn P.O. Md</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ida</u>		(Middle) <u>VERDELLA</u>		(Last) <u>TESTER</u>		(Month) <u>MAY</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>APRIL 24, 1862</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Tubb</u>				14. MOTHER'S MAIDEN NAME <u>Hood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>HERBERT JAMES TESTER</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>						<u>5 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						<u>20 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>						<u>20 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Renal Failure</u>						<u>5 yrs</u>	
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>11/19/50</u> to <u>5/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>55</u> , and that death occurred at <u>11:55</u> M., from the causes and on the date stated above.							
SIGNATURE <u>C. W. Prichard</u>		M.D. <u>715 Cotter Rd Glen Burnie Md</u>		ADDRESS (Street, city, town, state) <u>715 Cotter Rd Glen Burnie Md</u>		DATE SIGNED <u>5/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Marybeth Church Cem.</u>		LOCATION (City, town, or county) (State) <u>Md. P.O. - A.A. Co. Md.</u>	
24. REC'D BY REGISTRAR <u>May 25, 1955</u>		REGISTRAR'S SIGNATURE <u>L. Dealba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie Md</u>	

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04278

CERTIFICATE OF DEATH

Reg. Dist. No. 21

4272

1. PLACE OF DEATH

COUNTY

ANNE ARUNDEL

MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN)

10 ANNAPOLIS

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

63 ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MARYLAND COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

BALTIMORE

3V01-4

STREET ADDRESS

(If rural give location)

1647 W. NORTH AVE. #1

3. NAME OF DECEASED (Type or Print)

(First)

(Middle)

(Last)

Hubert

(NMI)

Jordan

4. DATE OF DEATH

(Month)

(Day)

(Year)

5

20

19 55

5. SEX

male

6. COLOR OR RACE

negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH

November 23, 1901

9. AGE last birthday

53

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

COOK

10b. KIND OF BUSINESS OR INDUSTRY

UNION Memorial

11. BIRTHPLACE (State or foreign country)

TAMPA FLORIDA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

577-14-9819

17. INFORMANT & ADDRESS

Bernice Jordan

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE

(A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

May 19, 1955

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 19, 1955, to May 20, 1955, that I last saw the deceased alive on May 20, 1955, and that death occurred at 10:50 P.M. from the causes and on the date stated above.

SIGNATURE

R. L. Richardson

M.D.

ADDRESS (Street, city, town, state)

110 - 11th St. & Ave. of the Arts, Wash. D.C.

DATE SIGNED

5/30/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

5/23/55

NAME OF CEMETERY OR CREMATORY

WOODLAND

LOCATION (City, town, or county)

WASHINGTON D.C.

24. RECD. BY REGISTRAR

REGISTRAR'S SIGNATURE

Thos. J. French

25. FUNERAL DIRECTOR'S SIGNATURE

Arliaton S. Phillips 1808 N MON. ST.

DATE

May 25, 1955

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MDH Form 100-100

1955

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY		4. CITY	
5. STREET		6. ZIP CODE	
7. NAME OF DECEASED		8. SEX	
9. AGE		10. RACE	
11. MARITAL STATUS		12. OCCUPATION	
13. CAUSE OF DEATH		14. MANNER OF DEATH	
15. MEDICAL HISTORY		16. MEDICAL OPINION	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF BURIAL	
23. SIGNATURE OF CEMETARY		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF BURIAL		26. SIGNATURE OF INTERMENT	
27. SIGNATURE OF BURIAL		28. SIGNATURE OF INTERMENT	
29. SIGNATURE OF BURIAL		30. SIGNATURE OF INTERMENT	
31. SIGNATURE OF BURIAL		32. SIGNATURE OF INTERMENT	
33. SIGNATURE OF BURIAL		34. SIGNATURE OF INTERMENT	
35. SIGNATURE OF BURIAL		36. SIGNATURE OF INTERMENT	
37. SIGNATURE OF BURIAL		38. SIGNATURE OF INTERMENT	
39. SIGNATURE OF BURIAL		40. SIGNATURE OF INTERMENT	
41. SIGNATURE OF BURIAL		42. SIGNATURE OF INTERMENT	
43. SIGNATURE OF BURIAL		44. SIGNATURE OF INTERMENT	
45. SIGNATURE OF BURIAL		46. SIGNATURE OF INTERMENT	
47. SIGNATURE OF BURIAL		48. SIGNATURE OF INTERMENT	
49. SIGNATURE OF BURIAL		50. SIGNATURE OF INTERMENT	
51. SIGNATURE OF BURIAL		52. SIGNATURE OF INTERMENT	
53. SIGNATURE OF BURIAL		54. SIGNATURE OF INTERMENT	
55. SIGNATURE OF BURIAL		56. SIGNATURE OF INTERMENT	
57. SIGNATURE OF BURIAL		58. SIGNATURE OF INTERMENT	
59. SIGNATURE OF BURIAL		60. SIGNATURE OF INTERMENT	
61. SIGNATURE OF BURIAL		62. SIGNATURE OF INTERMENT	
63. SIGNATURE OF BURIAL		64. SIGNATURE OF INTERMENT	
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67. SIGNATURE OF BURIAL		68. SIGNATURE OF INTERMENT	
69. SIGNATURE OF BURIAL		70. SIGNATURE OF INTERMENT	
71. SIGNATURE OF BURIAL		72. SIGNATURE OF INTERMENT	
73. SIGNATURE OF BURIAL		74. SIGNATURE OF INTERMENT	
75. SIGNATURE OF BURIAL		76. SIGNATURE OF INTERMENT	
77. SIGNATURE OF BURIAL		78. SIGNATURE OF INTERMENT	
79. SIGNATURE OF BURIAL		80. SIGNATURE OF INTERMENT	
81. SIGNATURE OF BURIAL		82. SIGNATURE OF INTERMENT	
83. SIGNATURE OF BURIAL		84. SIGNATURE OF INTERMENT	
85. SIGNATURE OF BURIAL		86. SIGNATURE OF INTERMENT	
87. SIGNATURE OF BURIAL		88. SIGNATURE OF INTERMENT	
89. SIGNATURE OF BURIAL		90. SIGNATURE OF INTERMENT	
91. SIGNATURE OF BURIAL		92. SIGNATURE OF INTERMENT	
93. SIGNATURE OF BURIAL		94. SIGNATURE OF INTERMENT	
95. SIGNATURE OF BURIAL		96. SIGNATURE OF INTERMENT	
97. SIGNATURE OF BURIAL		98. SIGNATURE OF INTERMENT	
99. SIGNATURE OF BURIAL		100. SIGNATURE OF INTERMENT	

NOTED: This form is to be filled out by the physician or other qualified person who has attended the deceased.

1. The deceased must be a resident of Maryland at the time of death.
2. The death must be a natural death.
3. The death must be a sudden death.
4. The death must be a violent death.
5. The death must be a death of unknown cause.
6. The death must be a death of unknown cause.
7. The death must be a death of unknown cause.
8. The death must be a death of unknown cause.
9. The death must be a death of unknown cause.
10. The death must be a death of unknown cause.

BUREAU V. 8

MAY 25 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4273

CERTIFICATE OF DEATH

04273

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Nr Annapolis</u>				TOWN <u>nr Annapolis</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 <u>Riva Road</u>				<u>Riva Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>JAUNITA KELLER</u>				<u>MAY 10, 1955</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sept. 23, 1901</u>	<u>53</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>house wife</u>		<u>own home</u>		<u>Abingdon, Va.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ben Ball</u>				<u>Sallie Sage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>Mr. Clarence Keller, Husband; same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
174X IMMEDIATE CAUSE (A) <u>Cancer of uterus</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 6, 1955</u> to <u>May 10, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Mamie Klemans</u> M.D.		<u>May 11, 55</u>		<u>to</u>		<u>Abingdon, Virginia</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Removal</u>		<u>May 11, 1955</u>		<u>HOPPING FUNERAL HOME</u>		<u>ANNAPOLIS, MD.</u>	
DATE <u>May 11, 1955</u>		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE			
		<u>[Signature]</u>		<u>[Signature]</u>			

CERTIFICATE OF DEATH

4273

32

State of Maryland

I, the undersigned, being a duly qualified physician, do hereby certify that

DECEASED

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS MENTAL ILLNESS

PREVIOUS PHYSICAL ILLNESS

PREVIOUS SOCIAL HISTORY

PREVIOUS PERSONAL HISTORY

PREVIOUS FAMILY HISTORY

PREVIOUS ENVIRONMENTAL HISTORY

PREVIOUS OCCUPATIONAL HISTORY

PREVIOUS RECREATIONAL HISTORY

PREVIOUS TRAVEL HISTORY

PREVIOUS EDUCATIONAL HISTORY

PREVIOUS MARITAL HISTORY

PREVIOUS PREGNANCY HISTORY

PREVIOUS CHILDREN

PREVIOUS SIBLINGS

PREVIOUS PARENTS

PREVIOUS GRANDPARENTS

PREVIOUS AUNT/UNCLES

PREVIOUS COUSINS

PREVIOUS NEPHEWS/NIECES

PREVIOUS SISTER-IN-LAW

PREVIOUS BROTHER-IN-LAW

PREVIOUS SPOUSE

PREVIOUS PARTNER

PREVIOUS CHILDREN

PREVIOUS SIBLINGS

PREVIOUS PARENTS

PREVIOUS GRANDPARENTS

PREVIOUS AUNT/UNCLES

PREVIOUS COUSINS

PREVIOUS NEPHEWS/NIECES

PREVIOUS SISTER-IN-LAW

PREVIOUS BROTHER-IN-LAW

PREVIOUS SPOUSE

PREVIOUS PARTNER

PREVIOUS CHILDREN

PREVIOUS SIBLINGS

PREVIOUS PARENTS

PREVIOUS GRANDPARENTS

BUREAU V. S.

MAY 12 1933

RECEIVED

PROTESTANT

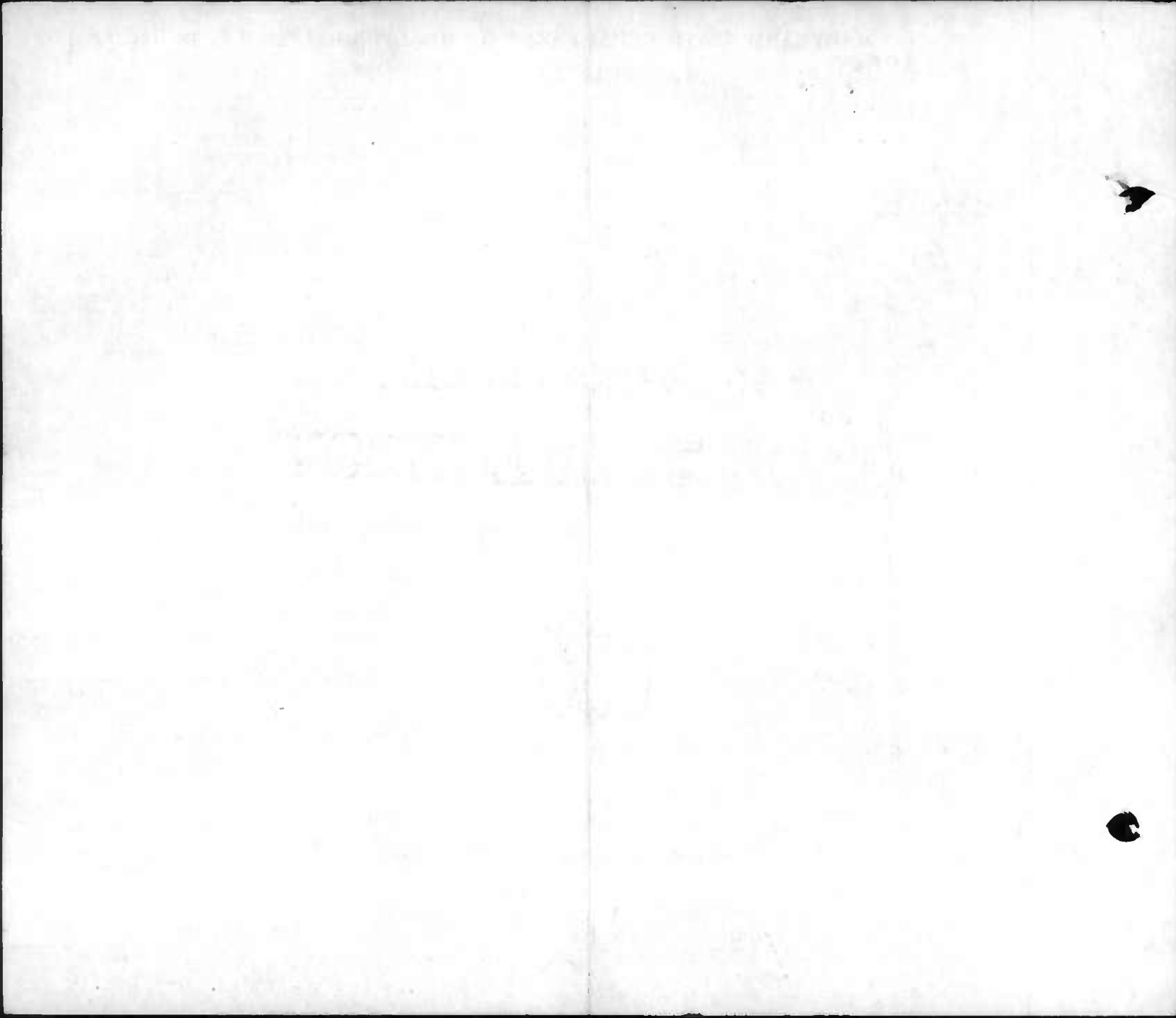
TO THE BOARD OF HEALTH

TO THE BOARD OF HEALTH

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04280
 4298 CERTIFICATE OF DEATH Reg. Dist. No. 23

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>A.A.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>A.A.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>50</u> TOWN <u>Brooklyn Park</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brooklyn Park</u>	<u>50</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>4400 Ritchie Highway</u>		STREET ADDRESS (If rural give location) <u>4400 Ritchie Highway</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY C. KNIPP</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>5/9/55</u> 19	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>6/1/72</u>
9. AGE last birthday: <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>	11. BIRTHPLACE (State or foreign country): <u>Ohio</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <u>Julian Cote</u>	
14. MOTHER'S MAIDEN NAME: <u>Juila Bourquian</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Family - Same</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>155X</u> Generalized Carcinomatosis			
ANTECEDENT CAUSE (B) Carcinoma of Gall Bladder			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/5</u> , 19 <u>54</u> , to <u>5/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/8</u> , 19 <u>55</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Mary C. Knipp</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>B</u>		DATE THEREOF <u>5/11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-10-55</u>		REGISTRAR'S SIGNATURE <u>James L. McCully</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>James L. McCully - 130 E. Fort Ave.</u>	



4299

CERTIFICATE OF DEATH

04281

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY **Anne Arundel** MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN **Severn** LENGTH OF STAY (in this place) **35 years**
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **S. Crain Highway Box 77**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Same.** COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN **Same**
 STREET ADDRESS **Same** (If rural give location) **/**

3. NAME OF DECEASED:

(First) **Bernard** (Middle) **Kruszewski** (Last)
 (Type or Print)

4. DATE OF DEATH:

(Month) **May** (Day) **25** (Year) **1955**

5. SEX:

M.

6. COLOR OR RACE:

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widowed

8. DATE OF BIRTH:

12/18/1876

9. AGE last birthday:

78 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

Retired farmer

10b. KIND OF BUSINESS OR INDUSTRY:

Germany

11. BIRTHPLACE (State or foreign country):

Germany

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Stanislaus kruszewski

14. MOTHER'S MAIDEN NAME:

Coniconda mennix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

NO

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

James kruszewski (son).

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause (a) **Cerebral hemorrhage**

Interval Between Onset And Death

33 hrs.

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(b) **hypertensive cardio vascular diseases.**

5 y.

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

5/24/55

19b. MAJOR FINDINGS OF OPERATION

5/28/55

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY

(CITY OR TOWN)

Balto. Co.

(COUNTY)

MD.

(STATE)

MD.

TIME (Month) (Day) (Year) (Hour) OF INJURY

5/24/55

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

5/25/55

22. I hereby certify that I attended the deceased from January 19. 50 to 5/25/55, 19....., that I last saw the deceased

alive on **5/24/55**, 19....., and that death occurred at **4.15 P.M.**, from the causes and on the date stated above.

SIGNATURE

Glen burnie Md.

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

5/28/55

NAME OF CEMETERY OR CREMATORY

Sacred Heart Mary

LOCATION (City, town, or county)

Balto. Co.

(State)

MD.

DATE REC'D BY LOCAL REGISTRAR

5-22-55

REGISTRAR'S SIGNATURE

Hedrick

24. FUNERAL DIRECTOR

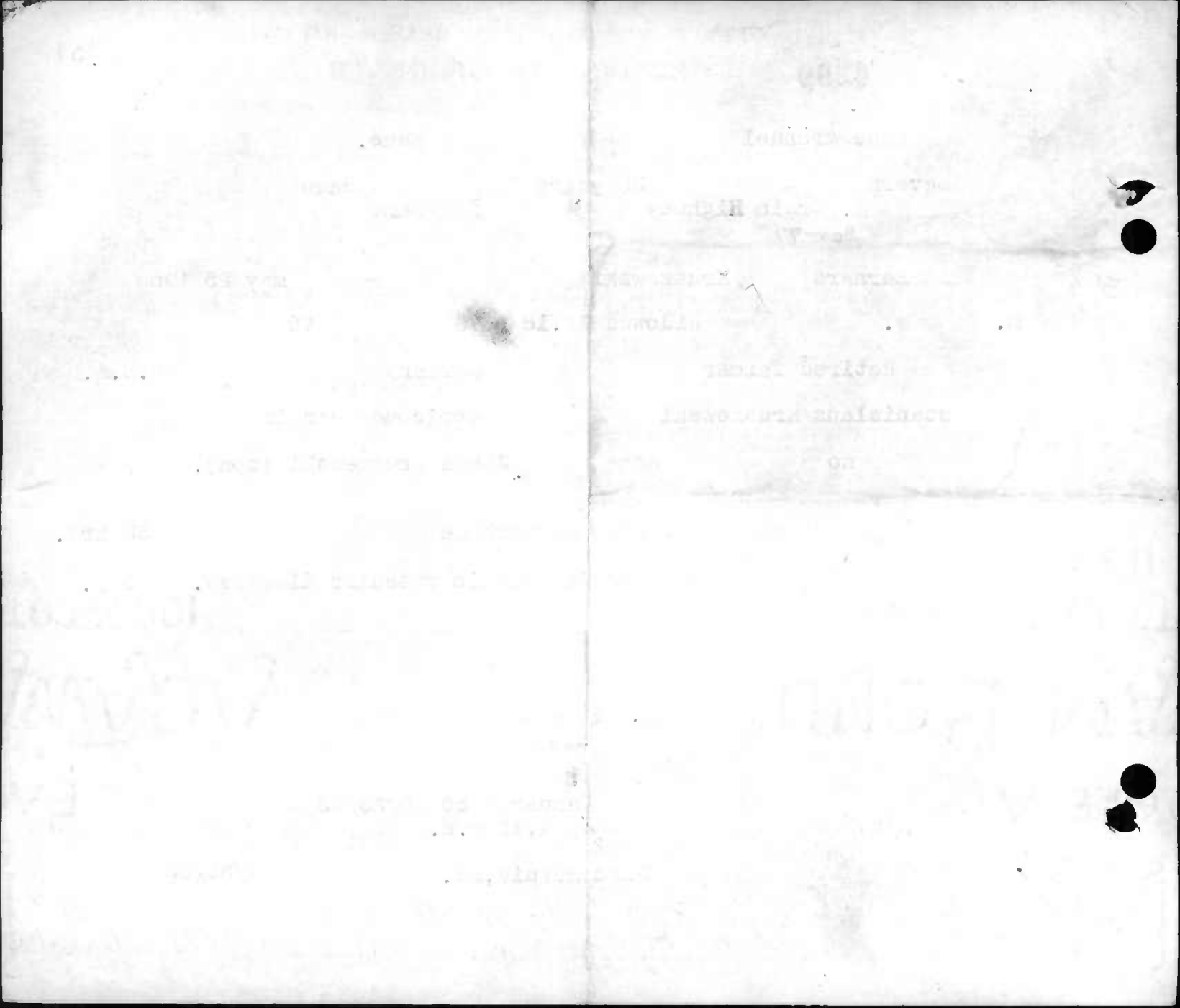
Mr. S. Fialkowski

ADDRESS

2007 Eastern Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4274

CERTIFICATE OF DEATH

04282

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CROWNSVILLE</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A. A GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u>		u	
3. NAME OF DECEASED (Type or Print) <u>HELEN (First) BREWSTER (Middle) LOVELL (Last)</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5-20-55</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>6-30-1884</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MAYWOOD Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. BREWSTER</u>				14. MOTHER'S MAIDEN NAME <u>MARY LEWIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>FRANK B. LOVELL SEVERNA PARK MD.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
446X IMMEDIATE CAUSE (A) <u>Uremia due to Nephrosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bone Marrow suppression</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Radioactive phosphorus</u>				<u>6 yr.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>-</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>55</u> , to <u>5/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>		M.D. <u>Annapolis Md</u>		ADDRESS (Street, city, town, state) <u>5/20/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Balchurn Memorial</u>		LOCATION (City, town, or county) (State) <u>Millersville Md</u>	
24. REC'D BY REGISTRAR <u>May 23, 1955</u>		REGISTRAR'S SIGNATURE <u>J. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sam M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	

CERTIFICATE OF DEATH

FILE NO. 100

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, Town, Village, or State)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. PLACE OF DEATH (City, Town, Village, or State)

9. TIME OF DEATH (Hour, Minute)

10. SIGNATURE OF PHYSICIAN (Print or Write)

11. SIGNATURE OF REGISTRAR (Print or Write)

12. SIGNATURE OF WITNESS (Print or Write)

13. SIGNATURE OF DECEASED (Print or Write)

14. SIGNATURE OF NEXT OF KIN (Print or Write)

15. SIGNATURE OF CLERGYMAN (Print or Write)

16. SIGNATURE OF CHURCH OFFICER (Print or Write)

17. SIGNATURE OF BURIAL OFFICER (Print or Write)

18. SIGNATURE OF FUNERAL HOME (Print or Write)

19. SIGNATURE OF CEMETERY (Print or Write)

20. SIGNATURE OF INTERVIEWER (Print or Write)

21. SIGNATURE OF INTERVIEWER (Print or Write)

22. SIGNATURE OF INTERVIEWER (Print or Write)

23. SIGNATURE OF INTERVIEWER (Print or Write)

24. SIGNATURE OF INTERVIEWER (Print or Write)

25. SIGNATURE OF INTERVIEWER (Print or Write)

26. SIGNATURE OF INTERVIEWER (Print or Write)

27. SIGNATURE OF INTERVIEWER (Print or Write)

28. SIGNATURE OF INTERVIEWER (Print or Write)

29. SIGNATURE OF INTERVIEWER (Print or Write)

30. SIGNATURE OF INTERVIEWER (Print or Write)

BUREAU V. 3

MAY 25 1955

RECEIVED

ENCLOSURE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4300

CERTIFICATE OF DEATH

04283

Reg. Dist. No.

Trans 89: film G182 6/3/55L

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY OR TOWN Crownsville Md.		LENGTH OF STAY (In this place) 22 hours		CITY OR TOWN Baltimore		STREET ADDRESS (If rural give location) 1635 Ruxton Ave.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) 1635 Ruxton Ave.			
3. NAME OF DECEASED (First) (Middle) (Last) Augustus Mackel				4. DATE OF DEATH (Month) (Day) (Year) May 28, 1955			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1904	9. AGE last birthday 51 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk. Laborer		10b. KIND OF BUSINESS OR INDUSTRY Water front		11. BIRTHPLACE (State or foreign country) Unknown - Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk. Albert Mackel				14. MOTHER'S MAIDEN NAME unk. Ella McDaniels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unk.		16. SOCIAL SECURITY NO. unk.		17. INFORMANT & ADDRESS Hospital Record			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						25 days	
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis, Far advanced							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/27 , 19 55 , to 5/28 , 19 55 , that I last saw the deceased alive on 5/28 , 19 55 , and that death occurred at 2:30 PM , from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state)		DATE SIGNED 5/29/ 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/2/55		NAME OF CEMETERY OR CREMATORY Int Auburn		LOCATION (City, town, or county) Baltimore Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Holland Funeral Home 1631 D and Hill Ave.	
DATE May 31, 1955							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4275

CERTIFICATE OF DEATH

04284

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hall</u>		<u>16x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES</u>		(Middle) <u>A</u>		(Last) <u>MARTIN</u>		(Month) (Day) (Year) <u>MAY 21 19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 19, 1955</u>	9. AGE last birthday <u>—</u> yrs. <u>—</u> mos. <u>2</u> days	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Neal Martin</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Neal Martin-Father- same as # 2</u>			
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
754.4 IMMEDIATE CAUSE (A) <u>Congenital Heart Disease</u>						<u>2 days.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 19</u> , 19 <u>55</u> , to <u>May 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>55</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>				ADDRESS (Street, city, town, state) <u>62 m br 11/3</u>		DATE SIGNED <u>5-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>May 22, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Thomas Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lee County, Virginia</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOIS, MD.</u>	
DATE <u>MAY 22, 1955</u> <u>2055389407</u>							

CERTIFICATE OF DEATH

12

2925

1994

307

2000

11. 11. 1952 6. 11. 1952

22

BUREAU V. S.

MAY 25 1955

RECEIVED

1002

2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4301

CERTIFICATE OF DEATH

04285

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Ohio</u>		COUNTY <u>Seneca</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ft George G. Meade</u>		<u>11 months</u>		TOWN <u>Bloomville</u>		<u>72 x -3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>				STREET ADDRESS (If rural give location)			
50				✓			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Angela</u> - <u>MC CLELLAND</u>				<u>14</u> <u>May</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>14 May 1955</u>				<u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>-</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Frederick N. McClelland</u>				<u>Annemarie L. Burtzlaff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Mrs. Frederick N. McClelland</u> <u>021 Park Ave, Apt 214, Laurel, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>776 x</u> IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>5 hrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>-</u>		<u>-</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>-</u>		<u>-</u>		<u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>-</u>		<u>M.</u>		<u>-</u>			
22. I hereby certify that I attended the deceased from <u>0145 14 May 1955</u>, to <u>0620 14 May 1955</u>, that I last saw the deceased alive on <u>14 May</u>, 19<u>55</u>, and that death occurred at <u>0620</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>JOSEPH S. ARDINGER</u>				<u>Ft GG Meade, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>16 May 55</u>		<u>Ft GG Meade, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>16 May 55</u>		<u>ARTHUR J. GORDON, CAPT., MSC</u>		<u>CHAP. QUIGLEY, Ft GG Meade, Md.</u>			

2055292240

CERTIFICATE OF DEATH

1915

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Duration of illness

10. Name of physician

11. Name of funeral director

12. Name of undertaker

13. Name of cemetery

14. Name of burial place

15. Name of interment place

16. Name of place of burial

17. Name of place of interment

18. Name of place of burial

19. Name of place of interment

20. Name of place of burial

21. Name of place of interment

22. Name of place of burial

23. Name of place of interment

24. Name of place of burial

25. Name of place of interment

26. Name of place of burial

27. Name of place of interment

28. Name of place of burial

29. Name of place of interment

30. Name of place of burial

31. Name of place of interment

32. Name of place of burial

33. Name of place of interment

34. Name of place of burial

35. Name of place of interment

36. Name of place of burial

37. Name of place of interment

38. Name of place of burial

39. Name of place of interment

40. Name of place of burial

BUREAU V. S.

MAY 20 1915

RECEIVED

RECEIVED

4276

CERTIFICATE OF DEATH

04286

Reg. Dist. No. 21

INSTRUCTIONS

1
X
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1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anna Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>aa</u>			
CITY OR TOWN <u>10 Annapolis</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>10 Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Boyd Drive Hillsmere Shore</u>		STREET ADDRESS (If rural give location) <u>Boyd Drive Hillsmere Shore</u>					
3. NAME OF DECEASED (Type or Print) <u>Melva M. Mitchell</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>August 29, 1895</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John William Grimm</u>				14. MOTHER'S MAIDEN NAME <u>Emma V. Grimm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>579-03-5667</u>		17. INFORMANT & ADDRESS <u>Oscar C. Mitchell</u> <u>Boyd Drive Hillsmere Shore</u> <u>Annapolis, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
237X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Tumor of Brain</u>						<u>8 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>5-9-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-9-</u> , 19 <u>55</u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Henry R. Mark</u>		M.D.		ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>5/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>removal</u>		DATE THEREOF <u>5/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Beaver Cemetery</u>		LOCATION (City, town, or county) (State) <u>Beaver, Pennsylvania</u>	
24. REC'D BY REGISTRAR DATE <u>May 12, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. H. Davis Co.</u>		ADDRESS <u>2901 14th St. N.W.</u> <u>Washington, D.C.</u>	

CERTIFICATE OF DEATH

1278

Reg. Div. No. 21

1. (LOCAL RESIDENTS) NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. MARITAL STATUS

7. COLOR

8. EDUCATION

9. RELIGION

10. PLACE OF DEATH

11. CAUSE OF DEATH

12. MANNER OF DEATH

13. TIME OF DEATH

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF NEXT OF KIN

19. SIGNATURE OF BURIAL OFFICIAL

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF CLERK

22. SIGNATURE OF CHIEF OF BUREAU

23. SIGNATURE OF ASSISTANT CHIEF

24. SIGNATURE OF DEPUTY CHIEF

25. SIGNATURE OF SECRETARY

26. SIGNATURE OF RECORDS MANAGER

27. SIGNATURE OF INSPECTOR

28. SIGNATURE OF ASST. INSPECTOR

29. SIGNATURE OF CLERK

30. SIGNATURE OF CHIEF OF BUREAU

31. SIGNATURE OF ASSISTANT CHIEF

32. SIGNATURE OF DEPUTY CHIEF

33. SIGNATURE OF SECRETARY

34. SIGNATURE OF RECORDS MANAGER

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36. SIGNATURE OF ASST. INSPECTOR

37. SIGNATURE OF CLERK

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43. SIGNATURE OF INSPECTOR

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245. SIGNATURE OF CLERK

246. SIGNATURE OF CHIEF OF BUREAU

4302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04287
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Edgewater</u>				TOWN <u>Washington, D.C.</u> 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>South River</u>				STREET ADDRESS (If rural, give location) <u>420 Buchanan St. NW</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)				
<u>JOSEPH PETER MONALDO</u>			<u>MAY 25, 19 55</u>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>March 30, 1937</u>	<u>18 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>High School</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Student</u>	11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Biagio Monaldo</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine Ulisse</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
<u>---</u>		<u>none</u>		<u>Mr Biagio Monaldo- Father- same as # 2</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>850.X</u> Immediate cause (a) <u>Drowning</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Under</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
<u>0</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>South River</u>		21c. (City or town) (County) <u>Edgewater Anne Arundel</u>		21d. (State) <u>Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 19, 55</u> <u>8</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>boat turned over</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that Death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>May 25, 1955</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 27, 55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG <u>May 26, 1955</u>		REGISTER'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Deal Funeral Home</u>		ADDRESS <u>4812 Georgia Ave. NW Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

State of Washington
County of King
City of Seattle
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that on the 27th day of May, 1955, at the residence of the deceased, I examined the body of
Name of Deceased
Age
Sex
Race
Color
Height
Weight
Build
Complexion
Hair
Eyes
Mouth
Nose
Ears
Throat
Lungs
Heart
Liver
Spleen
Stomach
Intestines
Pancreas
Prostate
Uterus
Vagina
Testes
Penis
Anus
Rectum
Bladder
Urethra
Vessels
Nerves
Joints
Bones
Cartilages
Tendons
Ligaments
Muscles
Skin
Nails
Teeth
Gums
Palate
Pharynx
Esophagus
Trachea
Bronchi
Larynx
Vocal Cords
Epiglottis
Diaphragm
Pericardium
Pleura
Parietal Pleura
Visceral Pleura
Peritoneum
Parietal Peritoneum
Visceral Peritoneum
Mesentery
Mesocolon
Mesenteric Glands
Sigmoid Colon
Rectum
Sigmoid Flexure
Cecum
Appendix
Ileocecal Junction
Ileum
Caecum
Sigmoidum
Rectum
Anus
Perianal Glands
Hemorrhoids
Fissures
Fistulae
Abscesses
Tumors
Polyps
Diverticula
Stenosis
Obstruction
Inflammation
Ulcers
Cancers
Metastases
Other Diseases
Cause of Death
Manner of Death
Time of Death
Place of Death
Signature of Medical Examiner
Date of Examination
Witnesses
Signature of Witnesses
Date of Signature
Place of Signature

BUREAU V. S.

MAY 31 1955

RECEIVED

MAY 30 1955

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04288

4277

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN ANNAPOLIS		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS ANNE ARUNDEL GENERAL				STREET ADDRESS (If rural give location) 310 Chesapeake Ave			
3. NAME OF DECEASED (First) (Middle) (Last) ALBERT F MONDAY				4. DATE OF DEATH (Month) (Day) (Year) MAY 14, 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married but separated	8. DATE OF BIRTH Sept. 18, 1889	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY House painting		11. BIRTHPLACE (State or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas F. Monday				14. MOTHER'S MAIDEN NAME Ida King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-2055		17. INFORMANT & ADDRESS Mrs Lucile Fisher-Daughter; same as # 2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis				INTERVAL BETWEEN ONSET AND DEATH ?			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) Adenoma of h. adrenal							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) Adenoma of h. adrenal							
19a. DATE OF OPERATION 5/14		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/10, 1955 , to 5/14, 1955 , that I last saw the deceased alive on 5/14, 1955 , and that death occurred at 6:55 P.M. from the causes and on the date stated above.							
SIGNATURE Maurice Klawns				ADDRESS (Street, city, town, state) Annapolis, Md			
DATE SIGNED 5/16/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 17, 1955		NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		LOCATION (City, town, or county) Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Hopping Funeral Home		25. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS ANNAPOLIS, MD.	
DATE May 17, 1955							

CERTIFICATE OF DEATH

1955

Form 10-55

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. DATE OF BIRTH

7. MARITAL STATUS

8. OCCUPATION

9. CAUSE OF DEATH

10. PLACE OF BIRTH

11. DATE OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF REPORTER

23. SIGNATURE OF CORONER

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF CLERK

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF DEPUTY SHERIFF

29. SIGNATURE OF CONSTABLE

30. SIGNATURE OF JAILER

31. SIGNATURE OF PRISONER

32. SIGNATURE OF GUARD

33. SIGNATURE OF WARDEN

34. SIGNATURE OF CHIEF OF POLICE

35. SIGNATURE OF DETECTIVE

36. SIGNATURE OF OFFICER

37. SIGNATURE OF SERGEANT

38. SIGNATURE OF PRIVATE

39. SIGNATURE OF CAPTAIN

40. SIGNATURE OF MAJOR

41. SIGNATURE OF LIEUTENANT

42. SIGNATURE OF COLONEL

43. SIGNATURE OF BRIGADE GENERAL

44. SIGNATURE OF DIVISION GENERAL

45. SIGNATURE OF CORPS GENERAL

46. SIGNATURE OF ARMY GENERAL

47. SIGNATURE OF NAVY GENERAL

48. SIGNATURE OF AIR FORCE GENERAL

49. SIGNATURE OF MARINE GENERAL

50. SIGNATURE OF COAST GUARD GENERAL

51. SIGNATURE OF CUSTOMS GENERAL

52. SIGNATURE OF EXERCISE GENERAL

53. SIGNATURE OF RECREATION GENERAL

54. SIGNATURE OF CULTURAL GENERAL

55. SIGNATURE OF EDUCATION GENERAL

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67. SIGNATURE OF RELIGION GENERAL

68. SIGNATURE OF ETHICS GENERAL

69. SIGNATURE OF LOGIC GENERAL

70. SIGNATURE OF METAPHYSICS GENERAL

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82. SIGNATURE OF RELIGION GENERAL

83. SIGNATURE OF ETHICS GENERAL

84. SIGNATURE OF LOGIC GENERAL

85. SIGNATURE OF METAPHYSICS GENERAL

86. SIGNATURE OF SCIENCE GENERAL

NOTIFICATION

1. NAME OF DECEASED
2. PLACE OF DEATH
3. SEX
4. AGE
5. RACE
6. DATE OF BIRTH
7. MARITAL STATUS
8. OCCUPATION
9. CAUSE OF DEATH
10. PLACE OF BIRTH
11. DATE OF DEATH
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR
14. SIGNATURE OF WITNESSES
15. SIGNATURE OF DECEASED
16. SIGNATURE OF NEXT OF KIN
17. SIGNATURE OF BURIAL OFFICIAL
18. SIGNATURE OF CHURCH OFFICIAL
19. SIGNATURE OF FUNERAL HOME
20. SIGNATURE OF CEMETERY
21. SIGNATURE OF INTERVIEWER
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38. SIGNATURE OF PRIVATE
39. SIGNATURE OF CAPTAIN
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41. SIGNATURE OF LIEUTENANT
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82. SIGNATURE OF RELIGION GENERAL
83. SIGNATURE OF ETHICS GENERAL
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85. SIGNATURE OF METAPHYSICS GENERAL
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88. SIGNATURE OF LITERATURE GENERAL
89. SIGNATURE OF HISTORY GENERAL
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93. SIGNATURE OF SOCIOLOGY GENERAL
94. SIGNATURE OF PSYCHOLOGY GENERAL
95. SIGNATURE OF PHILOSOPHY GENERAL
96. SIGNATURE OF THEOLOGY GENERAL
97. SIGNATURE OF RELIGION GENERAL
98. SIGNATURE OF ETHICS GENERAL
99. SIGNATURE OF LOGIC GENERAL
100. SIGNATURE OF METAPHYSICS GENERAL

RECEIVED
MAY 18 1955
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04289

CERTIFICATE OF DEATH

Reg. Dist. No. 21

4303

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural</u>		<u>DOA</u>		TOWN <u>Naval Station, Annapolis, Md.</u> <u>19</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>USNH, Annapolis, Maryland</u>				STREET ADDRESS (If rural give location) <u>NAVAL STATION, ANNAPOLIS, MD</u> <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Robert Gerald NELSON</u>				<u>May 29 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>20 March 1934</u>	9. AGE last birthday <u>21</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Emil Seigfried Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Etta Lenora (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>514 32 0635</u>		17. INFORMANT & ADDRESS <u>U.S. Naval Records</u>			
(If Yes, give war or dates of service)							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Injuries, Multiple Extreme #869</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Rural AA Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 29 553:15 am</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR? <u>Automobile accident (Pole)</u>			
22. I hereby certify that I attended the deceased from <u>DOA</u>, 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>3:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Philip George Logan USN</u>				DATE SIGNED <u>May 31, 1955</u>			
ADDRESS (Street, city, town, state) <u>U.S. Naval Hospital, Annapolis, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>May 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>to</u>		LOCATION (City, town, or county) (State) <u>Axtell, Marshall County, Kansas</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>			

RECEIVED

RECEIVED
JUN 2 1955
BUREAU V. 2

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

21

1955

1. NAME OF DECEASED JAMES H. HARRIS		2. PLACE OF BIRTH NEW YORK	
3. SEX Male		4. DATE OF BIRTH JAN 1 1901	
5. RACE White		6. OCCUPATION None	
7. MARITAL STATUS Married		8. PLACE OF DEATH New York	
9. DATE OF DEATH JUN 2 1955		10. TIME OF DEATH 10:00 AM	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN J. H. HARRIS		14. SIGNATURE OF REGISTRAR J. H. HARRIS	
15. SIGNATURE OF WITNESSES J. H. HARRIS		16. SIGNATURE OF DECEASED J. H. HARRIS	
17. SIGNATURE OF FUNERAL HOME J. H. HARRIS		18. SIGNATURE OF BURIAL PLACE J. H. HARRIS	
19. SIGNATURE OF CEMETERY J. H. HARRIS		20. SIGNATURE OF INTERMENT J. H. HARRIS	
21. SIGNATURE OF BURIAL PLACE J. H. HARRIS		22. SIGNATURE OF INTERMENT J. H. HARRIS	
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93. SIGNATURE OF BURIAL PLACE J. H. HARRIS		94. SIGNATURE OF INTERMENT J. H. HARRIS	
95. SIGNATURE OF BURIAL PLACE J. H. HARRIS		96. SIGNATURE OF INTERMENT J. H. HARRIS	
97. SIGNATURE OF BURIAL PLACE J. H. HARRIS		98. SIGNATURE OF INTERMENT J. H. HARRIS	
99. SIGNATURE OF BURIAL PLACE J. H. HARRIS		100. SIGNATURE OF INTERMENT J. H. HARRIS	

4304

04290
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE		COUNTY <u>47X-3</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Edgewater</u>				TOWN <u>Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>South River</u>				STREET ADDRESS (If rural, give location) <u>4300 Harewood Rd. N.E</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>The Rev. Dominic Palladino</u>				<u>May 26, 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>August 23, 1919</u>	
				9. AGE last birthday: <u>35</u> yrs.		10. IF UNDER 1 YEAR: Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Priest</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Mass.</u>	
13. FATHER'S NAME: <u>Antonio Palladino</u>				14. MOTHER'S MAIDEN NAME: <u>Pasqualina Caggiano</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Personal papers</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Drowning</u>						<u>Under 1</u>	
DUE TO							
Antecedent cause(s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>May 19, 1955</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>South river</u>		21c. (City or town) (County) (State) <u>Edgewater, Anne Arundel, Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 19, 1955</u> <u>am.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>boat turned over</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 26, 1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>May 27, 55</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lawrence, Mass.</u>	
DATE REC'D BY LOCAL REG. <u>May 26, 1955</u>		REGISTERAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Ben L. Hopping and Son</u>		ADDRESS <u>Annapolis, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU OF BUREAU

JAN 31 1955

RECEIVED

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4305

CERTIFICATE OF DEATH

04291

Reg. Dist. No. 28

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>City</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Crownsville</u>	LENGTH OF STAY (in this place) <u>7 yrs/ 4 mos.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>	<u>3601-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>		STREET ADDRESS (If rural give location) <u>707 Harlem Avenue</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>William</u> <u>Parker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>2</u> <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1874</u>
9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>-</u> <u>-</u> <u>-</u> <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jim Parker</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
451X IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Broncho-pneumonia</u>		<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Aortic Aneurysm</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>- - -</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - -</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u> <u>at work</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/5</u>, 19<u>55</u>, to <u>5/2</u>, 19<u>55</u>, that I last saw the deceased alive on <u>5/2</u>, 19<u>55</u>, and that death occurred at <u>3:15pm</u>, from the causes and on the date stated above.			
SIGNATURE <u>H. Leogard Heard Reissmann</u> M. D.		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>	
DATE SIGNED <u>5/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>5/4/55</u>		DATE THEREOF <u>5/4/55</u>	
24. REC'D BY REGISTRAR <u>May 3 '55</u>		REGISTRAR'S SIGNATURE <u>K. M. Joyce</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Miss Henry 578 W. Bigale</u>		ADDRESS <u>Balto. City Md</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES A. ROSS		JULY 1, 1955		BALTIMORE, MD	
AGE		SEX		RACE	
45		Male		White	
MARRIAGE		OCCUPATION		EDUCATION	
Married		Teacher		High School	
DATE OF MARRIAGE		PLACE OF BIRTH		DATE OF BIRTH	
JULY 1, 1910		BALTIMORE, MD		JULY 1, 1910	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
Heart Disease		Natural		Catholic Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
[Signature]		[Signature]		JULY 5, 1955	
LOCAL HEALTH OFFICER'S NAME AND ADDRESS		LOCAL HEALTH OFFICER'S SIGNATURE		LOCAL HEALTH OFFICER'S DATE	
[Name and Address]		[Signature]		JULY 5, 1955	

BUREAU V. S.

MAY 5 1955

RECEIVED

Handwritten signature

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04292

4306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Pr</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Churchton</i>		<i>65 years</i>		TOWN <i>Churchton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Bessie Irene Phipps</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>May-1-1955</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W.</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>June 17 1886</i>	
9. AGE last birthday <i>68</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Deale Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Ford</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Virginia Rodgers</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>William Lance Phipps, Churchton Md.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Cerebral Vascular Accident</i>						<i>48 hrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cerebral Arteriosclerotic Disease</i>						<i>Unk</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3:00 PM</i> , 19 <i>55</i> , to <i>1:00 PM</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>3:00 PM</i> , 19 <i>55</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Wm Lance Phipps</i>				ADDRESS (Street, city, town, state) <i>Upper Marlboro Md</i>		DATE SIGNED <i>2-29-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 3 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Quaker</i>		LOCATION (City, town, or county) (State) <i>Galesville Md</i>	
24. REC'D BY REGISTRAR <i>5-1-55</i>		REGISTRAR'S SIGNATURE <i>Elvis West Williams</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i>		ADDRESS <i>Galesville Md.</i>	

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4397

CERTIFICATE OF DEATH

04293

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Millersville (Rural)		2 weeks		TOWN Glen Burnie (Rural)		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sand's Nursing Home				STREET ADDRESS (If rural give location) Oakwood Rd.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Esther (Middle) Elizabeth (Last) Praley				(Month) May (Day) 25 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Married	January 5, 1920	35 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wood				14. MOTHER'S MAIDEN NAME Emma Stemmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 219 - 16 -1673		17. INFORMANT & ADDRESS Oakwood Rd. Frank J. Praley, Jr, Glen Burnie, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
193X IMMEDIATE CAUSE (A) Generalized Carcinomatosis						6 1/2	
DUE TO ANTECEDENT CAUSE(S) (B) Carcinoma of Brain						1 Year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 12, 1955, to May 25, 1955, that I last saw the deceased alive on May 24, 1955, and that death occurred at 5:30 AM, from the causes and on the date stated above.							
SIGNATURE <i>Edward J. Herring</i>				ADDRESS (Street, city, town, state) Glen Burnie, Md.		DATE SIGNED 5-25-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5/27/55		NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. M. Jones</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>James S. Herring</i> Hopping and Kirkley, Glen Burnie, Md.			
DATE May 26, 1955							

CERTIFICATE OF DEATH

FILE NO. 100

1. Usual Residence of Deceased

2. Date of Death

3. Cause of Death (Immediate)

4. Cause of Death (Underlying)

5. Place of Death

6. Age at Death

7. Sex

8. Marital Status

9. Occupation

10. Education

11. Date of Birth

12. Date of Admission to Hospital

13. Date of Discharge

14. Date of Death

15. Date of Burial

16. Date of Interment

17. Date of Cremation

18. Date of Autopsy

19. Date of Death

20. Cause of Death (Immediate)

21. Cause of Death (Underlying)

22. Place of Death

23. Age at Death

24. Sex

25. Marital Status

26. Occupation

27. Education

28. Date of Birth

29. Date of Admission to Hospital

30. Date of Discharge

31. Date of Death

32. Date of Burial

33. Date of Interment

34. Date of Cremation

35. Date of Autopsy

BUREAU V. S.

RECEIVED
MAY 31 1900

RECEIVED

1. Name of Deceased
2. Date of Death
3. Cause of Death (Immediate)
4. Cause of Death (Underlying)
5. Place of Death
6. Age at Death
7. Sex
8. Marital Status
9. Occupation
10. Education
11. Date of Birth
12. Date of Admission to Hospital
13. Date of Discharge
14. Date of Death
15. Date of Burial
16. Date of Interment
17. Date of Cremation
18. Date of Autopsy

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4308

CERTIFICATE OF DEATH

04294

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum Hghts.</u>		<u>2 mos.</u>		TOWN <u>Linthicum Hghts.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>209 Devon Court</u>				STREET ADDRESS (If rural give location) <u>209 Devon Court</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Charles</u> (Middle) <u>Henry</u> (Last) <u>Ray</u>				May 11, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Nov-29, 1868</u>	<u>86</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer (ret.)</u>		<u>A-A-County</u>		<u>Anne Arundel Co., Md.</u>		<u>U-S-A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John H. Ray</u>				<u>Sarah M. Magruder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Annie A. Ray</u> <u>209 Devon Court</u> <u>Linthicum Hghts. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592x IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Coro-vascular Disease</u>						<u>3 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>No</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Jan</u>, 19<u>55</u>, to <u>May 11</u>, 19<u>55</u>, that I last saw the deceased alive on <u>May 11</u>, 19<u>55</u>, and that death occurred at <u>5:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>James S. Beelings</u>				<u>108 Central Ave. Glen Burnie Md</u>		<u>May 13, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>May 14, 1955</u>		<u>Cedar Hill Cem.</u>		<u>Brooklyn RFD Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 19, 1955</u>		<u>Goldwell Hoodruff</u>		<u>R. V. Singleton</u>		<u>Glen Burnie Md</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. MEDICAL CERTIFICATION

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

BUREAU V. S.

MAY 23 1955

RECEIVED

ENCLOSURE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4309

04295

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY ARUNDEL MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR CONVALESCENT HOME ROUTE 2 BOX 376A				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 30014 OR TOWN STREET ADDRESS (If rural give location) 3116 BARCLAY ST. ✓			
3. NAME OF DECEASED (Type or Print) CECELIA (First) RAZAR (Middle) (Last) 4. DATE OF DEATH May 20 19 55				5. SEX F 6. COLOR OR RACE C 7. SINGLE, MARRIED, WIDOWED, DIVORCED, MARRIED 8. DATE OF BIRTH FEB. 9-1888 67 yrs. 9. AGE last birthday 67 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER 10b. KIND OF BUSINESS OR INDUSTRY SCHOOL 11. BIRTHPLACE (State or foreign country) BALTO. MD. 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME BENJAMIN CONNOR 14. MOTHER'S MAIDEN NAME NELLIE TERRY				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 16. SOCIAL SECURITY NO. MRS. KATHERINE ST. CLAIR 2044 RUXTON AVE.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) Cardiac failure ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic heart disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ARTERIOSCLEROTIC				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION 0 19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from May 19, 1955 , to May 20, 1955 , that I last saw the deceased alive on May 20, 1955 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.			
SIGNATURE Joseph Taler M.D.		ADDRESS (Street, city, town, state) 102 BALTIMORE-ANNAPOLIS BLVD. N.E. GLEN BURNIE, MD.		DATE SIGNED 5/20/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-23-1955		NAME OF CEMETERY OR CREMATORY St. Mary's		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR May 24, 1955		REGISTRAR'S SIGNATURE Louis J. DeAlba		25. FUNERAL DIRECTOR'S SIGNATURE Funeral Home ADDRESS 1631 Smith Hill Ave.			

CERTIFICATE OF DEATH

FILE NO.

PLACE HERE NAME OF DECEASED

AGE

DATE OF DEATH

PLACE HERE ADDRESS

SEX

DATE OF BIRTH

PLACE HERE CITY

STATE

DECEASED

CAUSE OF DEATH

PLACE HERE

PLACE HERE

BUREAU V. A.

MAY 24 1955

RECEIVED

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4310

CERTIFICATE OF DEATH

04296

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum</u>		<u>2 yrs.</u>		TOWN <u>Linthicum</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>708 Camp Meade Road</u>				STREET ADDRESS (If rural give location) <u>708 Camp Meade Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sarah</u> (Middle) <u>Estelle</u> (Last) <u>Rice</u>				(Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb-17-1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Millersville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P. Rice</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Steigleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Ester E. Boblitz</u>		<u>708 Camp Meade Rd. Linthicum Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170x IMMEDIATE CAUSE (A) <u>Cancer - Originating in breast</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>involving lungs & bones</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>leucemia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3:30</u> , 19 <u>52</u> , to <u>5:25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/25</u> , 19 <u>55</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Chas. E. Ball</u>		M.D. <u>Linthicum Md.</u>		ADDRESS (Street, city, town, state) <u>5726 N. 1st St. Baltimore, Md.</u>		DATE SIGNED <u>5/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baldwin Mem. Ch. Cem.</u>		LOCATION (City, town, or county) <u>Anne Arundel Co. Md.</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Dr. Caldwell Woodruff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Klingeborn</u>		ADDRESS <u>Shen Bennis, Md.</u>	

L. Deaeba

ENCLOSURE

RECEIVED
JUN 1 1955
BUREAU V. S.

4810 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. DATE OF DEATH

2. PLACE OF DEATH

3. SEX

BUREAU V. S.

JUN 1 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4311

CERTIFICATE OF DEATH

Reg. Dist. No.

04297

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE Md.	COUNTY Anne Arundel
CITY (If outside corporate limits, write OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN Elvaton		Elvaton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
00		Box 207	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
ALBERT HENRY ROSS		OF DEATH: May 1, 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
male	white	married	Nov. 5, 1897
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
57 yrs.		Md.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
Maintenance		Ft. Meade	
11. FATHER'S NAME:		12. MOTHER'S MAIDEN NAME:	
Samuel Thomas Ross		Ruth Mary Henry	
13. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		14. SOCIAL SECURITY No.	
2 yes World War I			
15. MEDICAL CERTIFICATION		16. INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 420.0		3 mo.	
ANTECEDENT CAUSE (S) Coronary Thrombosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic Heart Disease		2 yr.	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/24, 1953 to 5/1, 1955 that I last saw the deceased alive on 5/1, 1955 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
SIGNATURE Albert J. Hochel		ADDRESS 4111 Liberty Heights Ave DATE SIGNED 5/2/55	
M. D. Balto., Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		5/4/55	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Balto. National Cem.		Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Thm. J. Dickener	
		FUNERAL DIRECTOR Thm. J. Dickener ADDRESS Sous Balto. Md.	

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,
January 10, 1901.

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE,
JANUARY 10, 1899.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1899.

THE STATE OF NEW YORK,
COUNTY OF ALBANY.

I, the undersigned, Clerk of the Senate,

do hereby certify that the foregoing

is a true and correct copy of the

report of the Commissioners of the

Land Office, in response to a

resolution passed by the Senate,

January 10, 1899.

IN WITNESS WHEREOF, I have hereunto

set my hand and the seal of the

Senate, at Albany, this 10th day of

January, 1901.

CLERK OF THE SENATE.

ALBANY, N. Y.,

JANUARY 10, 1901.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4312

CERTIFICATE OF DEATH

04298

Reg. Dist. No. 24

Item 8. Film G182 6-6-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>				TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 39 - Oakwood Rd.</u>				STREET ADDRESS (If rural give location) <u>Box 39 Oakwood Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Gertrude</u>				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>1913</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>counter (Ref)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stand. Gas Equip. Co.</u>		9. AGE last birthday <u>41</u> yrs.		IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) <u>Balt. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-20-0426</u>		17. INFORMANT & ADDRESS <u>John Ruskie Oakwood Rd Glen Burnie</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
190X IMMEDIATE CAUSE (A) <u>Melanoma-Sarcoma & Metastasis</u>						8 Mos.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 19 55</u> , to <u>May 15 55</u> , that I last saw the deceased alive on <u>May 26 55</u> , and that death occurred at <u>6:40</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Dr. Macdonald MD</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>5-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 19 55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. D'Alto</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Burnie</u>		ADDRESS	
DATE <u>May 31, 1955</u>							

CERTIFICATE OF DEATH

1915

Form No. 100

1. DECEASED PERSON'S NAME (Last, first, middle)

DATE OF BIRTH
PLACE OF BIRTH

2. PLACE OF DEATH

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

3. SEX
4. RACE
5. OCCUPATION
6. DATE OF BIRTH
7. PLACE OF BIRTH
8. CAUSE OF DEATH
9. PLACE OF DEATH
10. DECEASED PERSON'S NAME (Last, first, middle)

BUREAU V. 51

RECEIVED

APR 22 1915

MAY 22 1915

RECEIVED
MAY 22 1915
MAY 22 1915

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04299

4313

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Illinois</u>		COUNTY <u>Will</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Port George G. Meade</u>		LENGTH OF STAY (in this place) <u>2 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Joliet</u>		<u>57X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>--</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>JOHN</u>		(Middle) <u>--</u>		(Last) <u>SABOTNIK</u>		(Month) (Day) (Year) <u>May 31 19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>December 16, 1878</u>		9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Penitentiary</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anton Sabotnik</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Slansek</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>339-05-4138</u>		17. INFORMANT & ADDRESS <u>Lt. Col Rex E. Sabotnik</u> <u>1502 Ingalls Road</u> <u>Glen Burnie, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) <u>Adenocarcinoma of rectum recurrent in Colostomy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 Months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Adenocarcinoma of rectum</u>						Indefinite	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION <u>11 October 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma of Rectum with metastasis carcinoma of</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? <u>pelvic lymph nodes</u>		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 May</u> , 19 <u>55</u> , to <u>31 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>31 May</u> , 19 <u>55</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Myron Myers</u>				ADDRESS (Street, city, town, state) <u>M.D. U. S. Army Hospital, Ft. G.G. Meade, Md 31 May 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4 June 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery</u>		LOCATION (City, town, or county) (State) <u>Joliet, Illinois</u>	
24. REC'D BY REGISTRAR <u>W. L. Saylor, 1st Lt MSC</u>		DATE <u>1 June 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>THOMAS W. SINGLETON</u>		ADDRESS <u>Glen Burnie, Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4314

CERTIFICATE OF DEATH

04300

Item 12, Film G181, 5/13/55 fcy

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Middleville</u>		<u>14 months</u>		TOWN <u>Edgewater</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sand Nursing Home</u>				STREET ADDRESS (If rural give location) <u>County Home</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES FREDERICK SCHMIDT</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>UNKNOWN</u>		8. DATE OF BIRTH <u>Apr. 28-1897</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		9. AGE last birthday <u>58</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Welfare Records, Annapolis Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/10</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				10 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>May 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 29</u> , 19 <u>55</u> , and that death occurred at <u>3:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>				DATE SIGNED <u>5-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 2, 55</u>		NAME OF CEMETERY OR CREMATORY <u>County Home</u>		LOCATION (City, town, or county) <u>Edgewater MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Elcie Thel William Bernard Hardisty Salvo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Salvo</u> ADDRESS			
DATE <u>May 1, 1955</u>							

CERTIFICATE OF DEATH

Reg. Code No.

1. Usual Residence (Place of Birth)

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

MAY 9 1925

RECEIVED

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4315

CERTIFICATE OF DEATH

04301

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY OR TOWN <u>Millersville (Rural)</u>		LENGTH OF STAY (in this place) <u>3 mos.</u>		CITY OR TOWN <u>Epping Forest, Annapolis, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sand's Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Amanda Grace Sentman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 29, 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 14, 1867</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mifflin Rowe</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Fapp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Epping Forest, Annapolis, Md.</u> <u>Robert Sentman,</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> IMMEDIATE CAUSE (A) <u>Arterio sclerotic Heart Disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 28</u> , 19 <u>55</u> , to <u>May 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>				ADDRESS (Street, city, town, state) <u>Cambridge Md</u>		DATE SIGNED <u>5-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Fernwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Nathaniel M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Kirkley</u> ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>			

BUREAU V. S.

1935

20

DE A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4278

CERTIFICATE OF DEATH

Reg. Dist. No. 21

04302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>a a</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>a a</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>10 Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lothian</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Homewood Convalescent</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Caroline Elizabeth Shepherd</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 28</u> <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Feb 14</u>	
9. AGE last birthday: <u>85</u> yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Gambrell, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Joshua L. Higgins</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Cicquata Hommard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>		17. INFORMANT'S ADDRESS: <u>Ralph Shepherd, Balt Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						<u>7 days</u>	
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>						<u>yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C) <u>Decubitus Ulcer</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>2+ mm.</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/24</u> , 19 <u>55</u> , to <u>5/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/28</u> , 19 <u>55</u> , and that death occurred at <u>1200</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Ralph M. Shepherd</u>				ADDRESS <u>M. D. Annapolis</u>		DATE SIGNED <u>5/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>May 31/55</u>		<u>St James</u>		<u>Troop Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 31, 1955</u>		<u>[Signature]</u>		<u>Burnell Hardisty</u>		<u>Holmesville Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1957

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4316

CERTIFICATE OF DEATH

04303

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mulberrx Hill</u>				TOWN <u>Mulberrx Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Felicia</u> (Middle) <u>SIMON</u> (Last)				(Month) <u>5</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u>	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE Colored</u>			<u>7-5-1885</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>ANNE ARUNDEL Co.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HENRY COOK</u>				<u>HARRIET STANSBERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>UNK.</u>				<u>DANIEL SIMON, Mulberrx Hill</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-5-55</u> to <u>5-11-55</u> , that I last saw the deceased alive on <u>5-6-55</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-15-55</u>		<u>Broadneck</u>		<u>Skidmore, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 13, 1955</u>		<u>[Signature]</u>		<u>William Reese #108 W. WASH. ST</u>		<u>ANNAPOLIS, Md</u>	

CERTIFICATE OF DEATH

4818

MAY 16 1955

1. NAME AND RESIDENCE OF DECEASED: [Illegible]

2. PLACE OF DEATH: [Illegible]

3. DATE OF DEATH: [Illegible]

BUREAU V. S.

MAY 16 1955

RECEIVED

4317

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: <i>Funeral.</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>A.A. Co.</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>A.A. Co.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Rural.</i>	LENGTH OF STAY (in this place) <i>20 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>None</i>		STREET ADDRESS (If rural give location) <i>/</i>	

3. NAME OF DECEASED: (First) <i>Carrie</i> (Middle) (Last) <i>Snowden</i>		4. DATE OF DEATH: (Month) <i>May</i> (Day) <i>20</i> (Year) <i>1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>Unk.</i>
9. AGE last birthday: <i>About 75 yrs.</i>		10. BIRTHPLACE (State or foreign country): <i>Unk.</i>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <i>Farm work.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unk.</i>	
13. FATHER'S NAME: <i>Unk.</i>		14. MOTHER'S MAIDEN NAME: <i>Unk.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>None</i>	
17. INFORMANT & ADDRESS: <i>William Reese -</i>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>422.1</i> Immediate cause (a) <i>Coron. Vascular Disease</i>		<i>3 months.</i>
Antecedent causes (s) (b) <i>_____</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>_____</i>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>		
19a. DATE OF OPERATION: <i>None</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>None</i>	PLACE (Home, farm, factory, street, office bldg., etc.) <i>_____</i>	(CITY OR TOWN) <i>_____</i> (COUNTY) <i>_____</i> (STATE) <i>_____</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>_____</i>

22. I hereby certify that I attended the deceased from *May 27*, 1955, to *May 28*, 1955, that I last saw the deceased alive on *May 27*, 1955, and that death occurred at *2 PM*, from the causes and on the date stated above.

SIGNATURE <i>James S. Bellamy MD</i>		DATE SIGNED <i>May 28, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>6-4-55</i>	NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>
DATE REC'D BY LOCAL REGISTRAR <i>June 4, 1955</i>	REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i>	24. FUNERAL DIRECTOR <i>William Reese, II - 108 Washington St.</i>	ADDRESS <i>Annapolis, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 9 1955
BUREAU V. S.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4279 CERTIFICATE OF DEATH

04305

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		28 years		TOWN <u>Rural</u>		<u>Pasadena</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
51 <u>U.S. Naval Academy</u>				<u>Box 178 Route 2</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Frederick Ferdinand STAEHLE (also Staehley)</u>				<u>5 23 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>10 January 1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Pipefitter</u>		<u>U.S. Government</u>		<u>Switzerland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Caspar Staehle</u>				<u>Amelia (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>Spanish-American</u>		<u>216-14-7172</u>		<u>Miss Fredda Staehle</u> <u>Box 178 Rt 2, Pasadena, Md. (Daughter)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Occlusion, coronary artery</u>						<u>420.1</u>	
ANTECEDENT CAUSE(S) DUE TO						<u>Immediate</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on..... <u>5-23-</u> <u>1955</u>, and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. H. Martinat</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>E. H. MARTINAT LT (MC) USNR</u>				<u>M.D. U.S. Naval Academy, Annapolis, Md.</u>		<u>5-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/26/55</u>		<u>Meadowridge Cem.</u>		<u>Howard Co.,</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 25, 1955</u>		<u>Thm. J. French</u>		<u>Thm. J. Tiekner & Sons - Baeb</u>		<u>17 Ma</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4318

CERTIFICATE OF DEATH

04306

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Millersville</u>				TOWN <u>Gambrills</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sands Nursing Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JAMES</u> <u>R B</u> <u>STOCKETT</u>				<u>MAY 20, 1955</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept. 30, 1866</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>Own Farm</u>		<u>Davidsonville, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>James Benjamin Stockett</u>				14. MOTHER'S MAIDEN NAME <u>Emily Bean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Mr. Marvin H. Stockett—Son—same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>May 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>55</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>		M.D.		ADDRESS (Street, city, town, state) <u>Gambrills Md</u>		DATE SIGNED <u>5-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>All Hallows Cemetery</u>		LOCATION (City, town, or county) (State) <u>Davidsonville, A.A., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>K M Soja</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ben L. Hopping Jr.</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	
DATE <u>May 22/55</u>							

CERTIFICATE OF DEATH

REG. NO. 100

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, Town, or Village)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. DATE OF DEATH (Month, Day, Year)

9. PLACE OF DEATH (City, Town, or Village)

10. SIGNATURE OF PHYSICIAN (Print or Write)

11. SIGNATURE OF REGISTRAR (Print or Write)

12. SIGNATURE OF WITNESS (Print or Write)

13. SIGNATURE OF DECEASED (Print or Write)

14. SIGNATURE OF DECEASED (Print or Write)

15. SIGNATURE OF DECEASED (Print or Write)

16. SIGNATURE OF DECEASED (Print or Write)

17. SIGNATURE OF DECEASED (Print or Write)

18. SIGNATURE OF DECEASED (Print or Write)

19. SIGNATURE OF DECEASED (Print or Write)

20. SIGNATURE OF DECEASED (Print or Write)

21. SIGNATURE OF DECEASED (Print or Write)

22. SIGNATURE OF DECEASED (Print or Write)

23. SIGNATURE OF DECEASED (Print or Write)

24. SIGNATURE OF DECEASED (Print or Write)

25. SIGNATURE OF DECEASED (Print or Write)

26. SIGNATURE OF DECEASED (Print or Write)

27. SIGNATURE OF DECEASED (Print or Write)

28. SIGNATURE OF DECEASED (Print or Write)

29. SIGNATURE OF DECEASED (Print or Write)

30. SIGNATURE OF DECEASED (Print or Write)

31. SIGNATURE OF DECEASED (Print or Write)

32. SIGNATURE OF DECEASED (Print or Write)

33. SIGNATURE OF DECEASED (Print or Write)

34. SIGNATURE OF DECEASED (Print or Write)

35. SIGNATURE OF DECEASED (Print or Write)

36. SIGNATURE OF DECEASED (Print or Write)

37. SIGNATURE OF DECEASED (Print or Write)

38. SIGNATURE OF DECEASED (Print or Write)

BUREAU V. S.

MAY 26 1955

RECEIVED

RECEIVED

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4319

CERTIFICATE OF DEATH

04307

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Odenton</u>		<u>15 yrs.</u>		TOWN <u>Odenton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
1				1			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Floyd Leander Tester</u>				<u>May 13 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 5, 1880</u>	<u>75</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter (ret.)</u>		<u>U.S. Gov't.</u>		<u>Johnson City, Tennessee</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Elkana Tester</u>				<u>Mary Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>Unknown</u>		<u>Mr. Russell S. Armiger 310 Vernon Ave Glen Burnie Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cancer of Lt Ovary -</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastasing to surrounding area -</u>						<u>1 yr -</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cardio-Vascular Disease</u>						<u>2-3 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1938</u> , to <u>5/13</u> , 1955 , that I last saw the deceased alive on <u>5/13</u> , 1955 , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above. SIGNATURE <u>Chas. L. Ball</u> ADDRESS (Street, city, town, state) <u>Linthicum</u> DATE SIGNED <u>5/13/55</u> M.D. <u>Linthicum</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 17, 1955</u>		<u>First Church of God</u>		<u>Gambells, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 17, 1955</u>		<u>Clara Schupp</u>		<u>R. V. Singleton</u>		<u>Glen Burnie Md</u>	
		<u>L. J. Deaeba</u>					

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and

7/11/82

BUREAU V. S.

MAY 18 1955

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4280

CERTIFICATE OF DEATH

04308

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10 Annapolis Md</u>		<u>4 days</u>		TOWN <u>Edgewater</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>THOMAS</u> (Last) (First) (Middle) <u>HEZAKIAH</u>				<u>MAY</u> <u>16</u> <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>UNKNOWN</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Harwood MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Thomas</u>				14. MOTHER'S MAIDEN NAME <u>LIRACE Giles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Randall Thomas Mayo, MD</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>My father's Cardiovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Grade III</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 10, 1955</u> to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Richard E. ...</u>				ADDRESS (Street, city, town, state) <u>110-Clay St. ...</u>		DATE SIGNED <u>5/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hope Chapel</u>		LOCATION (City, town, or county) <u>Edgewater MD</u>	
24. REC'D BY REGISTRAR <u>May 19, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Giltsville Md</u>	

4320

CERTIFICATE OF DEATH

04309

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL OR and give nearest town)	
<i>x Odenton, Md.</i>	<i>30 yrs</i>	<i>Same</i>	<i>x</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>RT 1, box 393</i>		<i>Same</i>	<i>1</i>

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<i>MAMIE ELIZ. THOMAS</i>		<i>May 25 1955</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Wid.</i>	8. DATE OF BIRTH: <i>Mar. 13, 1885</i>
9. AGE last birthday: <i>70</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Washington, D.C.</i>	
11. BIRTHPLACE (State or foreign country): <i>Yer. USA</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>James HAYES (dec.)</i>		14. MOTHER'S MAIDEN NAME: <i>Mrs Mary Hayes (dec.)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>none</i>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Son - Leon H. Thomas - Same address</i>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>420.0</i>		
Immediate cause	(a) <i>arteriosclerotic Heart Disease</i>	<i>3 yrs</i>
Antecedent causes (s)	(b) <i>Hypertension</i>	<i>10 yrs</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(c)	

11. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <i>none</i>	
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>none</i>	PLACE (Home, farm, factory, street, office bldg. etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from <i>May 25, 1955</i> , to <i>May 25, 1955</i> , that I last saw the deceased alive on <i>May 25, 1955</i> , and that death occurred at <i>from the causes and on the date stated above.</i>			
SIGNATURE <i>H.F. Manuzak M.D.</i>		DATE SIGNED <i>5-25-55</i>	
(Degree or title)		ADDRESS <i>901 Edgerly Rd, Glen Burnie, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>5/26/55</i>	<i>5/26/55</i>	<i>Washington</i>	<i>D.C.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>May 26 1955</i>	<i>Charles H. Hays</i>	<i>Superior James B</i>	<i>1435 York St</i>
note: This is a patient of Dr. Skeritts for last 3 yrs & pronounced dead during his absence from town.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

043A0

4321

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH - COUNTY <u>99.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u>		COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Town</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>		<u>16 X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>303 Pine Grove Dr.</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>BERNARD LYLE VALENTINE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 25 1955</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>1-6-1928</u>	
				9. AGE last birthday <u>27</u> yrs.		If under 1 year Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charlottesville Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard P. Valentine</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Reynolds</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>WW II</u>	
				17. INFORMANT AND ADDRESS <u>Mrs. Jeanne Valentine</u>		(2)	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
922.8 Immediate cause (a) <u>Accidental drowning</u>						<u>1/2 hr</u>	
Antecedent cause(s) (b) <u>Disease or condition, if any, giving rise to the above cause stating the underlying cause last</u>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Robertson's River</u>		(CITY OR TOWN) <u>River</u>		(COUNTY) <u>AG.</u> (STATE) <u>MD.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 25 55 7:35 PM</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Accidental drowning (Swimming)</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>D. Borsulich M.D.</u> ADDRESS <u>Annapolis MD</u> DATE SIGNED <u>5/25/55</u>							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>5-28-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		LOCATION (City, town, or county) <u>Suitland</u> (State) <u>MD.</u>	
DATE REC'D BY LOCAL REG. <u>May 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Edward Collinson</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>		ADDRESS <u>Washington, D.C.</u>	

RECEIVED

JUN 1 1955

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4322

CERTIFICATE OF DEATH

04311

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>MD.</u>		COUNTY <u>Anne Arundel</u>	
CITY OR TOWN <u>Severna Park</u>		LENGTH OF STAY (In this place) <u>45 yrs</u>		CITY OR TOWN <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u>				STREET ADDRESS (If rural give location) <u>Cypress Creek Rd!</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John DANIEL VoGEL SANG</u>				<u>MAY 16 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>27 Dec 1889</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Vogel SANG</u>				14. MOTHER'S MAIDEN NAME <u>CAROLYN. DIMMICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>7</u>		16. SOCIAL SECURITY NO. <u>720</u>		17. INFORMANT & ADDRESS <u>Mrs. WOLF Severna Park MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>4201 MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1955</u> to <u>MAY 16 1955</u> , that I last saw the deceased alive on <u>APRIL 15 55</u> and that death occurred at <u>DEPTA</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hahn</u>				ADDRESS (Street, city, town, state) <u>Severna Park, Md. 16 MAY 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u>	
24. REC'D BY REGISTRAR <u>May 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Louis J. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Luck</u>		ADDRESS <u>5365 Bayford</u>	

CERTIFICATE OF DEATH

Reg. No. 10

1. LOCAL HEALTH OFFICE (Name of District)

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. MARITAL STATUS

9. CAUSE OF DEATH

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF OFFICIAL

21. SIGNATURE OF OFFICIAL

22. SIGNATURE OF OFFICIAL

23. SIGNATURE OF OFFICIAL

24. SIGNATURE OF OFFICIAL

25. SIGNATURE OF OFFICIAL

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41. SIGNATURE OF OFFICIAL

42. SIGNATURE OF OFFICIAL

43. SIGNATURE OF OFFICIAL

BUREAU V. S.

MAY 18 1955

RECEIVED

RECEIVED

RECEIVED

4323

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

COUNTY A.A.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Brooklyn

HOSPITAL OR INSTITUTION OR STREET ADDRESS

701 Church St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY A.A.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn

STREET ADDRESS

(If rural give location) 701 Church St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

FRANK F. Von Celin

4. DATE OF DEATH:

(Month)

(Day)

(Year)

5 - 3 19 55

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

M

8. DATE OF BIRTH:

5-4-05

9. AGE last birthday:

49 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired:

FIRE WORKER U.S.I.A.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

HOWARD

14. MOTHER'S MAIDEN NAME:

MARY Schuch.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

4 NO

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Family - Same

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a) DUE TO

CORONARY THROMBOSIS

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

Atherosclerotic C.V. disease

(c)

Interval Between Onset And Death

2 hrs.

2

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from April 1954, to May 3, 1955, that I last saw the deceased

alive on May 3, 1955, and that death occurred at 5:30 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John R. Schuch

M.D.

4700 Pennington Ave

5/3/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (city, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-5-55

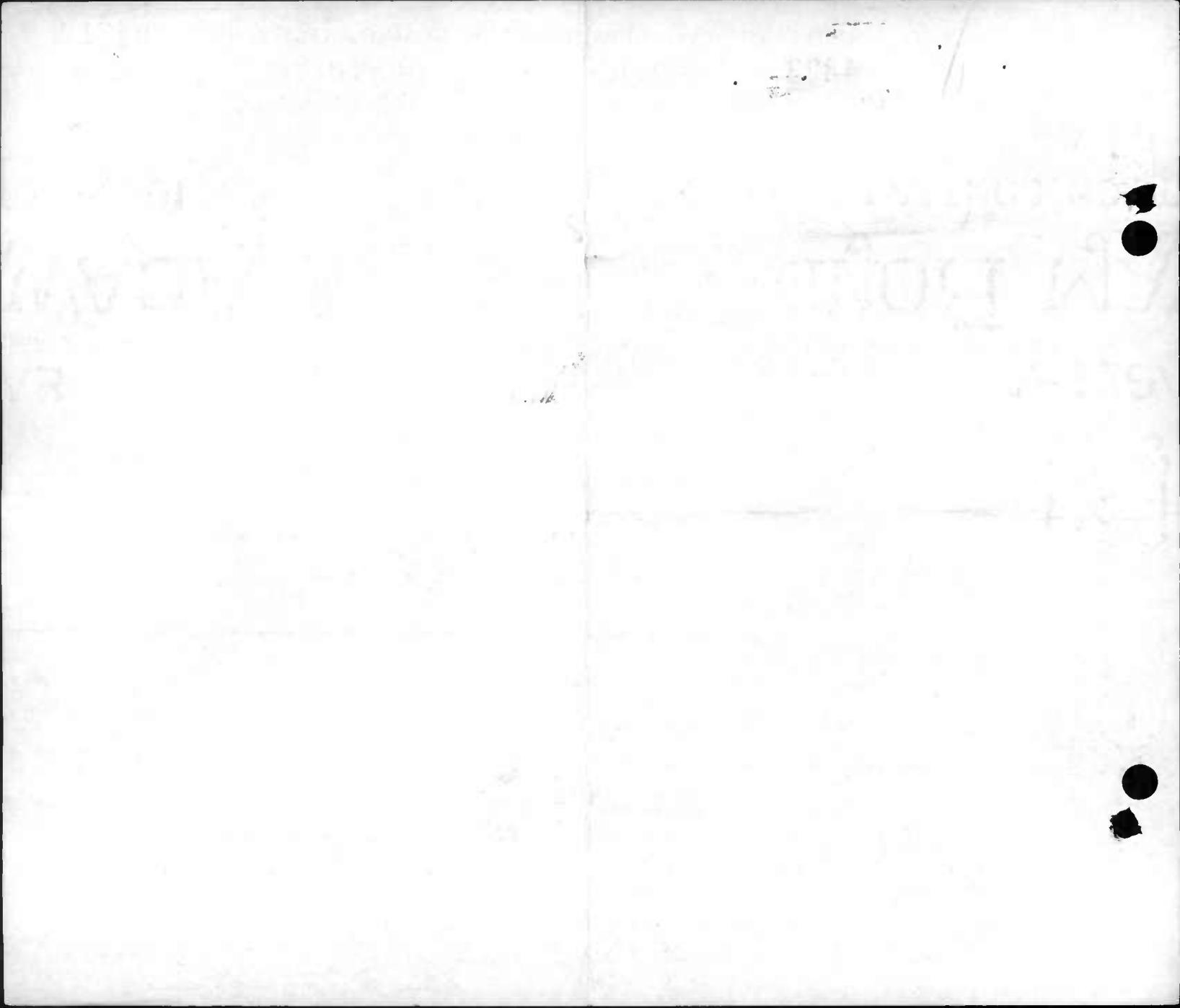
A.W. Schuch

J.L. McCarney

1308 Fort Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certifying age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04313

4324 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crownsville		21yrs. 2mos.		TOWN Baltimore City		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) Hanover & York Streets			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Walter		(Middle) Wallace		(Last) Wallace		(Month) 5 (Day) 14 (Year) 19 55	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Unknown	9. AGE last birthday 67? yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months — Days —		Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furrier		10b. KIND OF BUSINESS OR INDUSTRY Fur		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Samuel Wallace				14. MOTHER'S MAIDEN NAME Anna May Booth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Known to us since 2/28/34	
IMMEDIATE CAUSE (A) General Paresis							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/21 , 19 48 , to 5/14 , 19 55 , that I last saw the deceased alive on 5/14 , 19 55 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE L. Benedict, M. D.		ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 5/15/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 5/23/55		NAME OF CEMETERY OR CREMATORY Brown's Chapel		LOCATION (City, town, or county) (State) Calvert Co. Port Republic			
24. REC'D BY REGISTRAR May 19 '55 K.M. Joyce		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell Prince Frederick, Md.		ADDRESS	

DEATH CERTIFICATE OF DEATH

REGISTRATION NO.

1. Usual Residence (How, by Decedent)

2. Date of Death
3. Place of Death
4. Cause of Death
5. Manner of Death

6. Name of Decedent
7. Sex
8. Race
9. Age
10. Date of Birth

11. Name of Physician
12. Name of Hospital
13. Name of Funeral Home
14. Name of Burial Place

15. Name of Informant
16. Name of Registrar
17. Name of Burial Place

18. Name of Burial Place
19. Name of Burial Place
20. Name of Burial Place

BUREAU V. 2

MAY 23 1955

RECEIVED

REGISTRATION

MARYLAND

04314
STATE DEPARTMENT OF HEALTH

4325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PASADENA</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PASADENA</u> M.D.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Light & Mission St.</u>				STREET ADDRESS (If rural, give location) <u>Light & Mission Sts.</u>			
3. NAME OF DECEASED (First) <u>Christine</u> (Middle) <u>-</u> (Last) <u>Walter</u>				4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>March 26 - 1877</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		9. AGE last birthday <u>78</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Washington DC.</u>	
13. FATHER'S NAME <u>Augustus Appelstiel</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
14. MOTHER'S MAIDEN NAME <u>Sofia</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>312-24-8730</u>			
17. INFORMANT AND ADDRESS <u>Daughter - Mrs Irma S. Bussey</u>							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 Immediate cause						(a) <u>Respiratory & Circulatory Failure</u>	
Antecedent cause(s)						(b) <u>myocardial Infarction</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last						(c) <u>Arteriosclerotic Cardio Vascular Disease</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
PLACE (Home, farm, factory, street, office bldg., etc.)				(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour)				HOW DID INJURY OCCUR?			
INJURY OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>9 May</u> , 19 <u>55</u> , to <u>25 MAY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24 May</u> , 19 <u>55</u> , and that death occurred at <u>8745A</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Halim</u> (Degree or title)				ADDRESS <u>Severna Park Md</u> DATE SIGNED <u>25 May 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/28/55</u>		<u>Landon Park</u>		<u>Calverton Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-26-55</u>		<u>R. R. Halim</u>		<u>Edward Luck</u>		<u>5305 Nayford</u>	

MARGIN RESERVED FOR BINDING

1

1955
78
1877

1952

1952

CERTIFICATE OF DEATH

1952



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

4326

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Gambrills</u>		<u>7 years</u>		TOWN <u>Gambrills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S.N.A. dairy Farm</u>				STREET ADDRESS (If rural give location) <u>U.S.N.A. Dairy Farm.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sarah</u> (Middle) <u>Ann</u> (Last) <u>Waters</u>				(Month) <u>May</u> (Day) <u>28</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>June 13 1874</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House work (Retired)</u>		<u>Own Home</u>		<u>Anne Arundel Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>James R. Warfield</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. John Hutchins, Gambrills, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>2 days</u>			
443X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>							
ANTECEDENT CAUSE(S) DUE TO				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive Cardio-Vascular Disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 47</u> , 19 <u>47</u> , to <u>May 28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>55</u> , and that death occurred at <u>4 P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Sherritt</u>				ADDRESS (Street, city, town, state) <u>Gambrills Md</u>		DATE SIGNED <u>5-28-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Seyvern Cross Roads Md.</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Katherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Kingston</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>May 31, 1955</u> <u>L. J. Orsella</u>							

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		JUNE 1 1965	
CITY		STATE	
COUNTY		AGE	
SEX		RACE	
EDUCATION		OCCUPATION	
MARRIAGE		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
IMMEDIATE CAUSE		MEDICAL OPINION	
INTERMEDIATE CAUSE		FUNDAMENTAL CAUSE	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	

BUREAU V. S.

JUN 1 1965

RECEIVED

NOTIFICATION OF DEATH TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

4327

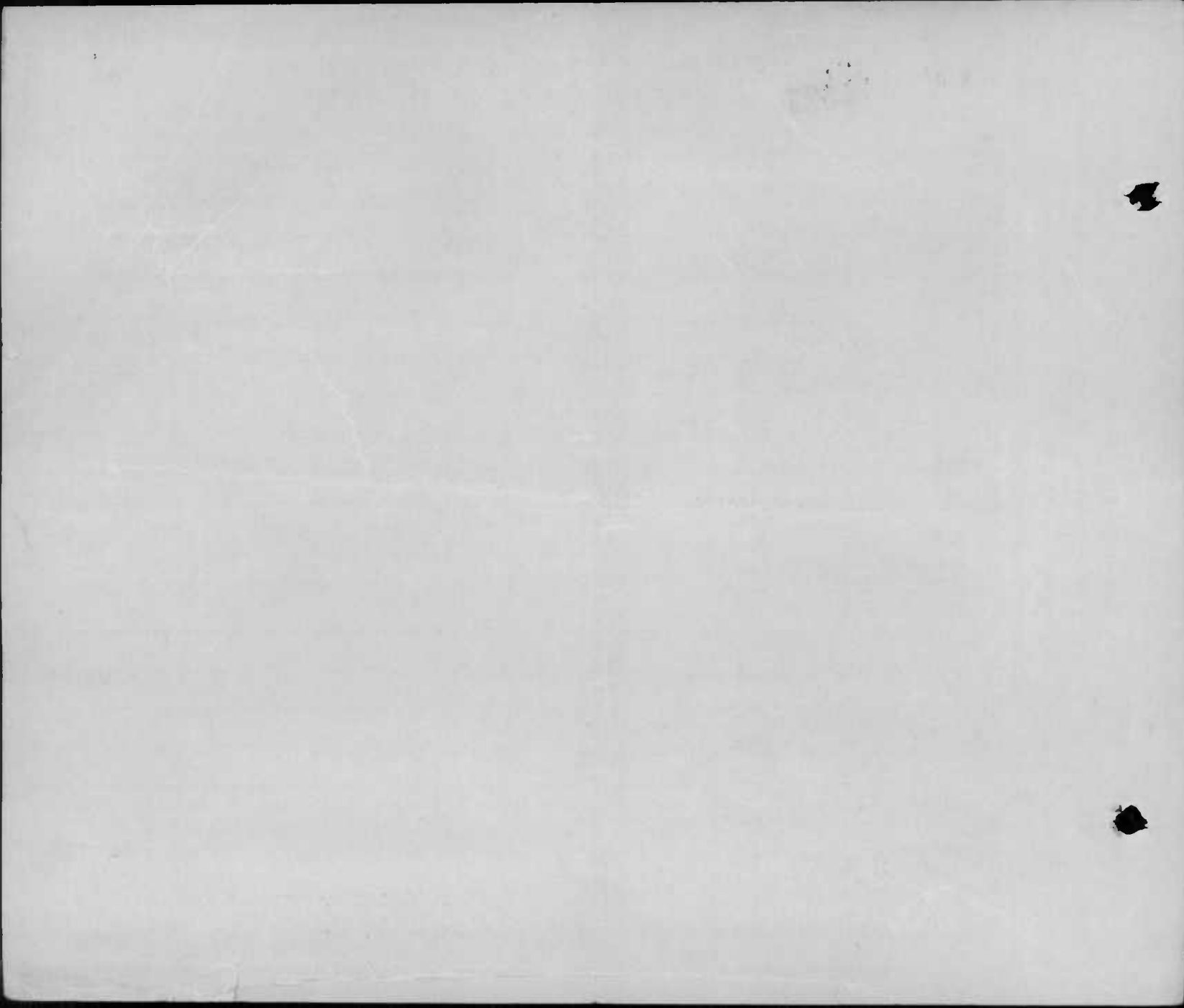
CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04316

Reg. Dist. No. 25

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>a.a.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> 50	
TOWN <u>Brooklyn</u>		TOWN <u>Brooklyn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>237-Edgevale Rd.</u>		STREET ADDRESS (If rural, give location) <u>237 Edgevale Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MILTON-RAYMONS-WAXTER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 27 1950</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6/19/88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
11. BIRTH PLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Waxter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Florence Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Navy 1914</u>		16. SOCIAL SECURITY NO. <u>215-07-7140</u>	
17. INFORMANT AND ADDRESS <u>Mrs. F. Waxter (wife)</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) <u>Sudden</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Lucas H. P. Anderson</u> (Degree or title) <u>Medical Examiner</u>		ADDRESS <u>4001 Ritchie Hwy</u> DATE SIGNED <u>6/27/50</u>	
23. BURIAL, CREMATION OR DISPOSAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/31/50</u>	
NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		LOCATION (City, town, or county) <u>Balto. Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>5-31-50</u>		REGISTRAR'S SIGNATURE <u>C. W. Anderson</u>	
24. FUNERAL DIRECTOR <u>George J. Jones</u>		ADDRESS <u>4001 Ritchie Hwy</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4328

CERTIFICATE OF DEATH

04317

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE-ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>ANNE-ARUNDEL</u>	
CITY OR TOWN <u>Severn-RFD</u>		LENGTH OF STAY (in this place) <u>54 years</u>		CITY OR TOWN <u>Severn RFD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>New-Cut-Road</u>				STREET ADDRESS (if rural give location) <u>New-Cut-Road</u>			
3. NAME OF DECEASED (Type or Print) <u>William W. Wheeler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 25 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Sept. 30-1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired (Farmer)</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William W. Wheeler</u>				14. MOTHER'S MAIDEN NAME <u>Liza-Stinchcomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>New-Cut-Road Clinton-Wheeler-Severn-RFD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0 Arterio-sclerotic Heart Disease</u>						<u>2 Years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arterio sclerosis</u>						<u>10 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Peripheral Vascular Disease</u>						<u>2 Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 24</u> , 19 <u>55</u> , to <u>May 25</u> , 19 <u>55</u> that I last saw the deceased alive on <u>May 24</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>				ADDRESS (Street, city, town, state) <u>Glen-Barnie Md</u>		DATE SIGNED <u>5-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May-28-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glen-Haven</u>		LOCATION (City, town, or county) (State) <u>Glen-Barnie-Maryland</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Clara Housley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E.R.V. Singleton</u>		ADDRESS <u>Glen, Barnie, Md.</u>	

CERTIFICATE OF DEATH

1935

REG. DIST. NO.

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

BUREAU V. S.

JUN 1 1935

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH TO BE FURNISHED TO THE NEAREST RELATIVE OR TO THE NEXT OF KIN, OR TO THE PERSON IN CHARGE OF THE BURIAL, AND TO THE LOCAL HEALTH OFFICE, AND TO THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND TO THE BUREAU OF VITAL STATISTICS, WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04318

4329

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH- COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>A. A. Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, R. 30.</u> LENGTH OF STAY (in this place) <u>23 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanham Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lanham-Annapolis Jct. Rd.</u>		STREET ADDRESS (If rural, give location) <u>Lanham-Annapolis Jct. Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Richard A. Whitehead</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 16, 1889</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R. Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Richard Whitehead</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>David Whitehead, Lanham, Md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>540.0</u> Immediate cause (a) <u>Peritonitis</u> Antecedent cause(s) (b) <u>Gastric Ulcer</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>M. B. - Pt. refused hospitalization.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>5 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>May 8th</u> , 19 <u>55</u> , to <u>May 11th</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 11th</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Frank Shipley, M.D.</u>		DATE SIGNED <u>5/12/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 14, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Long Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lanham, Maryland</u>	
24. FUNERAL DIRECTOR <u>De W. L. Davidson, Lanham, Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 7 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 18 Film G182 6-17-55 ams

04319

4330

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Ft GG Meade, Md.</u>		<u>unknown</u>		OR TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>		STREET ADDRESS (If rural give location)		<u>1500 Eutaw Place</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Jack E. Williamson</u>				<u>May 27 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>single</u>	<u>25 November 1933</u>	<u>21</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Soldier</u>		<u>U.S. Army</u>		<u>West Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Bannon Williamson</u>				<u>Mabel Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>5 Oct 53 to death</u>		<u>unknown</u> <u>Army Service Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION						<u>DOA</u>	
784.1 IMMEDIATE CAUSE (A) <u>Aspiration of gastric contents.</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Vomiting of undetermined origin. (not accidental)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>2</u>						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>DOA</u>		<u>DOA</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DOA</u>, 19<u>approx</u>, to <u>DOA</u>, 19<u>approx</u>, that I last saw the deceased alive on <u>0910</u>, 19<u>approx</u>, and that death occurred at <u>0910</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James M. Foley</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>JAMES M. FOLEY, LT. COL. MC</u>				<u>M.D. Ft GG Meade, Maryland</u>		<u>27 May 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>Buskark Cemetary</u>		<u>Matowan, Ky.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>WILLIAM L. SAYLOR, 1/Lt MSC</u>		<u>WILLIAM COOK</u>		<u>Baltimore, Maryland</u>			
DATE <u>27 May 55</u>							

CERTIFICATE OF DEATH

4830

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

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51. SIGNATURE OF DECEASED

52. SIGNATURE OF DECEASED

53. SIGNATURE OF DECEASED

54. SIGNATURE OF DECEASED

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56. SIGNATURE OF DECEASED

57. SIGNATURE OF DECEASED

58. SIGNATURE OF DECEASED

BUREAU V. S.

JUN 1 1965

RECEIVED

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

4281

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH - COUNTY <u>Q. Q.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Q. Q.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
TOWN <u>Annapolis</u>		TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>C. G. General Hosp.</u>		STREET ADDRESS (If rural, give location) <u>304 Washington St.</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>L.</u> (Last) <u>Windsor Jr.</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2-2-1935</u>
9. AGE last birthday <u>20</u> yrs.		10. If under 1 year: Months <u>5</u> Days <u>15</u> Hours <u>15</u> Mins. <u>1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. Kind of Business or Industry <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>James L. Windsor Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Monobray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Katherine M. Windsor</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

976X

Immediate cause

Gun Shot Wound - Skull

INTERVAL BETWEEN ONSET AND DEATH

Instant

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY HOME

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY May 15 5:15 A.M.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Self Inflicted

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL INFORMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 16, 1955

J. J. Trench

John M. Taylor Sons Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.
MAY 18 1955
RECEIVED
BUR